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ORIGINAL ARTICLES.

ANTISEPTIC OBSTETRICS.

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The microbe reigns. In truth, its revels
In human woe, now beat the Devil's.
The greatest wonder, fear and dread
That now surrounds the child-birth bed;
Old doctors never dreamed it so,
When waiting on parturient ladies;
And if their getting up was slow,
The microbes didn't get the babies.
Carbolic acid, Listerine,
Were never thought of in those days,
Nor the Biochloride squirt-gun seen,
All primed to inundate the case.
The only exhortation given,
Was keep your bed, but change your linen.

Nearly fifty years in the practice of obstetrics and the management of 2400 cases of labor and after-treatment of the parturient women, in which number are included about all the varieties and complications of labor at full term besides numerous cases of abortion, ought, I think, entitle an experience and observation from a clinical standpoint, to some consideration in the department of obstetric medicine. Uterine, pelvic and peritoneal inflammations have been of a very small percentage following parturition, and that under what is now termed the "old fogy" regime in use before the present antiseptic parturium was in vogue.

It is proper that both sides of any great question should be heard, and all the facts collected, therefore, I offer a few thoughts on antiseptic midwifery as viewed to-day by so many eminent accoucheurs.

All admit that this is an age of culture and of scientific investigation, and that the medical profession is not behind in pushing onward and upward to the high place it is destined to occupy among the other sciences. But is there not danger in the struggle for pre-eminence among our-

selves? Some are traveling so fast that they are found on some high eminence, way beyond the rank and file, watching for the whole army to overtake them. Wrapt up in their own conceptions, with microscope in hand, they stand making mouths at us, ignoring all the learning and clinical observations of the past, discarding *in toto* all etiology of diseases as taught by physiologists and pathologists of the past, and the ever present microbe, with them enters into every avenue of life and every tissue of the body—a specific bacillus for each human malady. *Wonderful Discovery!* In fact, our clothing, beds, carpets, food and drink are swarming with deadly bacteria, ever ready to pounce upon and annihilate us. But the horrid feature of this wonderful discovery is that the parturient woman is the one above all others, whose life is brought into jeopardy. This haunts the medical attendant day and night, and the entire *arcanum* of microbe-destroyers is brought into requisition to save her from an untimely grave. I admit all this savors of great learning; people stare and wonder, and one would think it was only by miracle or direct interposition of Divine Providence that our mothers survived the process of parturition if the present opinions relative to the management of the parturient female are correct.

If true, the larger number of women, especially in private practice, ought and necessarily would be the subjects of septicæmia, or toxic poisoning in some form, because of the absolute impracticability of carrying out the antiseptic precautions. But facts show such is not the case. I

have had patients placed under the most trying ordeal of poverty and filth, minus all the comforts of life, and yet these would do well, and that in the filth of their uterine secretions, no undergarments for a change, the very kind of soil to foster bacteria; yet these same women were soon up and attending to the duties of the housewife, having had no unfavorable symptoms. I acknowledge it makes us old physicians feel quite humble, and sometimes we almost feel that all our past reading and clinical observation is *nil*, when we see the young-fledged M. D. coming around with his weapons of offensive and defensive warfare against the supposed myriads of germs that threaten the citadel with destruction; but we apply the unction of "*vita brevis—ars longa*."

Not long ago a physician said to me that he held he would be guilty of malpractice if before he made a vaginal examination in labor he failed to disinfect his hands, clean out his nails, and spray his person; yet this same physician has been engaged in an extensive obstetrical practice for thirty years and has not until recently paid any attention to antiseptic treatment in his midwifery practice. He has been a successful physician in this department to my certain knowledge, very few of his cases having been attacked with parturient inflammations. I requested an explanation for such a singular statement, and his reply was: "You had better be out of the profession than out of fashion." And he "did not propose to remain behind the practice of the day."

I believe the practice of the past for safety and a speedy convalescence from all forms of labor will compare favorably with the present notions and observances. If all is true that is claimed for the present practice, hundreds must necessarily be exposed from the absolute impossibility, under the circumstances, of methodically carrying out the practice. But then we have in cleanliness, soft water and good soap, with good ventilation, I opine, what will meet all the exigencies in about all the cases of parturition. Such has been my experience. A few years ago I was called in to see and treat the husband of a poor woman who a few days previously had given birth to a child. The season was one of oppressive heat. The stench from her undergarments and bed was intolerable from the decomposition of the lochial discharge, which was in excess, yet

this woman had a good recovery. Every man who has been in practice a number of years has seen similar cases. Now according to modern opinions, this woman ought to have fallen a victim to some one of the puerperal maladies; but perhaps the bacteria if they did generate in such favorable soil were not so vicious and blood-thirsty as the bacilli of modern times. I repeat, pure air, good alimentation, water and soap are nature's antiseptics, and are about all any parturient female requires. In purely surgical practice, there is no doubt but antiseptics are of great utility, and are indispensably necessary; but there can be no question but what the same extremes have been reached as has taken place in relation to the best remedy in acute inflammation, when judiciously and scientifically employed, viz., blood letting. Common sense and conservatism in medicine is the safe rule; it is the only rational one. The notion that every ill which befalls the parturient female is produced by a specific microbe, and calls for a routine of an unnecessary and often impracticable line of management, which results more to the enhancement of her medical adviser in the opinion of his patient than it does for her protection and comfort, is more, I opine, a fashion in modern medicine than a reality.

I cannot divorce myself from the opinions of the past in regard to the etiology of diseases, especially those which are characterized by acute inflammation—puerperal peritonitis as an example. That the greatest number of the phlogistic maladies are produced histogenically or autogenically, I think is beyond cavil; the peculiar *materies-morbi* so acting upon the blood as to result in acute inflammation. Then, again, meteorologically considered, the direct or remote effects of cold are all factors in the etiology of disease. Several cases of puerperal fever have come under my observation that could be traced to the direct influence of cold upon the system.

Fearful epidemics of puerperal fever prevailed in Edinburgh in 1793, and in Paris, Vienna and Aberdeen in 1795. These epidemics were written up by such clinicians and pathologists as Lock, Hunter, Clark, Campbell, Tonille, Armstrong, Meekell, Lee, Collins, Furguson, Dance, Bovine, Duges and Gordon and Columbat. These authors, all of whom were actively engaged in the treatment of

this fearful epidemic, both in hospitals and private practice, all speak of and describe a peculiar condition of the atmosphere that unquestionably prevailed and gave rise and continuance to the epidemic.

I think the judicious and unprejudiced physician will not adopt in haste and unreservedly any of the leading doctrines advanced in modern medicine. Looking back over the literature and clinical experiences of the past, he will still see a great deal to admire and embrace in the systems of Brown, of Cullen, of Darwin, of Broussais, and even of the fanciful Hahnemann; although when offered to his acceptance as doctrines of universal application, he may very reasonably refuse his assent.

The advocates of bacteriology endeavor to support the doctrine with the microscope and by culture; by the phenomena of post-mortem examination, and by arguments founded on physiological principles. It is affirmed that bacteria are present in this and that disease, therefore, the bacteria must necessarily be the factor in the etiology of the disease, and are responsible for all the morbid changes. Now parasite conditions may be the result of previously existing morbid conditions, therefore, the mere presence of any variation from the normal is no proof that this condition was the primary cause of the disease in question, but it is in all probability only the result of pre-existing morbid action. Admitting that such manifestations are as universal as they are asserted to be, is there not much reason to believe that very frequently, at least, this very condition supervened during the course of the disease as a consequence, rather than that pathological conditions having been pre-established, and become the immediate cause of so many febrile and inflammatory diseases. We frequently see inflammation supervene in parts exposed to observation many days after general fever has been fully established, why not then other products devoid of organizable lymph and pus cells—the result of morbid changes going on in the diseased parts, yet not absolutely known to the searching investigation and reasoning powers of the pathologist. The theory is as yet a *vera et quæstio*.

QURAY—If parturient females are in so great danger, why does it not bring all women alike subject to the baneful influence of this dangerous microbe, or is

it alone confined to the civilized and cultured? The Greenlanders mostly do all their common business just before and after their delivery, and a peritoneal inflammation is seldom heard of. Long tells us that the Chippewa women as soon as their child is born go into the water and immerse it saying "Oway saggonosh payshik shomagonith," or "here is a young warrior."

Lempriere says: "Women in Morocco suffer but little inconvenience from child bearing."

"The Shangalla women bring forth children with the utmost ease, and never rest or confine themselves after delivery."

Immediately after delivery of the placenta, all clots should be removed from the vagina, and an agreeable bandage applied; all saturated clothing removed; the room kept well ventilated; a light yet nutritious diet allowed, and perfect rest in the recumbent posture enjoined. Then follows a discharge of a sanguinous fluid from the uterus for a few days, which becomes greenish, and lastly pale, and decreases in quantity, disappearing altogether within a month, and often in a shorter time. This is called the lochial discharge. During this flow it is only necessary that the vagina and external parts be daily washed with tepid milk and water. Constipation should be avoided; and the condition of the lacteal secretion looked after. The above is under all ordinary circumstances about all that is necessary for the medical advisor to do for his patient, and the above strictly enforced will, as a rule of conduct, be all that any woman will require for the successful recovery from parturition.

In conclusion, should this article fall into the hands of the older members of the profession who are competent to judge, it will, if faulty do little harm; but should it fall into the hands of the student of midwifery, it will prove useful or injurious to society, according to the correctness of the principles it contains. When I consider how important the diseases of women are, especially of the parturient woman, and how important the prudent management of labor and the entire puerperal state, I think I comprehend the responsibility which falls on those who presume to practice this art. And I feel that what I have stated as my honest conviction, will be found to agree with the observation and experience of our best teachers and practitioners of obstetrics.

COMMUNICATIONS.

SURGICAL SHOCK.*

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It is proposed in this communication to briefly consider the nature of surgical shock, and then to take up its treatment in detail. Shock is a condition of the body which is characterized by feebleness and rapidity of action of the heart, by the shallowness and frequency of respiration, by the lowering of the temperature of the body, and by the lessened activity of most of its functions. Intellection, digestion, and the secretion of urine all are more or less in abeyance. It is probable, also, that the processes of assimilation and metabolism are profoundly interfered with. Perspiration is usually free, the body being covered with a cold, clammy sweat. This, however, is due not to the increased activity of the sweat glands, but rather to an arrest of the activity of their cells, so that they simply act as strainers for the watery part of the blood to pass through them.

There can be no question that vitality is at a low ebb when shock exists, but there is some difference of opinion as to the real physiology or pathology involved. It is generally accepted that shock is a manifestation of paresis of the nervous system, its symptoms being due to lessened and irregular innervation. The question as to whether the cerebro-spinal or the sympathetic system is most involved is in dispute, and we do not propose at this time to attempt the elucidation of the question. As a matter of fact, injury of the body in any of its parts can bring about shock. Injury to certain parts of the body are especially liable to produce shock. These parts are the testicle and urethra, in the male, the ovary (in a lessened degree) in the female, and the abdominal viscera. Examples of shock from injury to these structures are common, and familiar to every one of experience. The familiar experiment of temporarily arresting the heart's action of the

frog by a blow upon the abdomen is a striking illustration. Leaving aside the disputed points at issue, we wish to consider certain facts because of their very practical bearing upon the therapeutics of surgical shock. Among the most important symptoms of shock is the lessened force and greater frequency of the heart's beat. The activity of the respiratory centre, also, is much lessened. The superficial blood-vessels are contracted, so that the surface of the body is pale and even blanched. The temperature of the body is lowered below the normal. These facts are indisputable, and a recognition of the existence of these conditions forms the basis for rational therapeutics. Heat must be restored to the body; the heart and respiratory centres must be stimulated to do their work; and the superficial blood-vessels must be dilated, so that the circulation may be equalized by affording a channel for the blood which has been retained in the great veins of the abdomen. The practice which I followed for some years to accomplish these results will now be given.

Treatment of Shock.—The most important point in the treatment of shock is its prevention. Much can be done by prudent management, either to avoid shock or to lessen its degree. In selecting the date for operation a time should be chosen when the patient is in good condition. Almost always this is possible. It is only in emergency cases, and in patients who are suffering from a disease whose progress is steadily and rapidly downward, that preparatory treatment will not put them in better condition. All patients requiring operation should receive careful study, and every therapeutic indication should be met before operation. Especially should the condition of the emunctories be looked after. The bowels, skin and kidneys should be put in good condition by the use of baths, purgatives (especially broken doses of calomel and salines), and the abundant ingestion of water. The *morale* of the patient should

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not be neglected, as much can be done, by stimulating the courage of the timid and allaying the fears of the despondent, to make the patient look forward to the operation with courage and without dread. All these matters should be attended to prior to the day of operation. The temperature of the room in which the operation is done should be high, from 75° to 85° F. In such a room the loss of heat from the patient by radiation is much less when the operation is done in a cool room. Loss of heat from the patient can be lessened also by the manner in which she is dressed. It is best that she be well wrapped in blankets, and that as little of the skin surface be exposed to the air as the necessities of the particular operation permit. For the same reason the use of wet towels or gauze about the patient is to be deprecated. Evaporation from such wet material chills the patient. Much can be done also by the proper administration of the anaesthetic. Patients should not be drowned in ether. Enough only should be given to maintain anaesthesia, unless to meet a certain indication, absolute relaxation is required. The prevention of hemorrhage, and the avoidance of rough handling of the patient, especially of the abdominal viscera, are matters of the greatest importance in preventing shock. The careful surgeon gives due attention to each and all of these matters of detail, and no one so much appreciates their importance as he who has to deal constantly with grave operations. This applies especially to the abdominal surgeon, because in many cases, when he begins an operation the life of the patient depends upon its completion. He cannot do a part of it and postpone the rest to another day. In many of the long, tedious operations which he is called upon to do, involving multiple visceral adhesions, the very life of the patient itself depends upon attention to every detail to prevent shock, so that he may have time to complete the operation *secundem artem*.

The active treatment of shock consists in supplying heat to the body which has been lost, in stimulating the heart to better work, in counteracting nervous depression, and in overcoming irregular action, especially on the part of the vaso-motor nervous system, until reaction shall occur and the vitality of the patient can be sustained by alimentation. In describ-

ing the treatment of shock I shall simply give an account of my own practice in the treatment of this condition.

If during the operation the patient begins to suffer from shock and here is reason to expect that this will increase, especially when the operation is not yet completed, I begin at once actively to treat it. One-fifteenth of a grain of sulphate of strychnia and one-fiftieth of digitalin is given hypodermically, and the dose of strychnia is repeated every fifteen minutes until some improvement is manifested in the pulse, until a fifth of a grain is given. If improvement does not manifest itself promptly, and especially if shock be profound or if the patient has been markedly prostrated before the operation, a hundredth of a grain of atrophia sulphate and two or three minims of a 1 per cent. aqueous solution of nitroglycerine are given hypodermically. In still other cases from three to six grains of citrate of caffeine are administered in addition. During this time hot-water bottles have been put about the patient, and if the operation is an abdominal section, at times warm water is poured into the peritoneal cavity. I have also employed hot beef-tea enemas, but, as a rule, an enema is not given, because it interferes with the completion of the operation, which is just as important as any one detail in the treatment of shock if not more so. In fact, it is of the highest importance to complete the operation as rapidly as is consistent with safe work. The same is true of the after-dressing of the patient, who should be put to bed as promptly as is feasible.

The bed should have been warmed by having hot-water bottles in it while the operation was in progress, and in all cases in which shock is a marked feature, the sheets should be removed and the patient placed between warm, dry blankets. At this stage the use of whiskey by enema is of service, and at times it is proper to use whiskey during the operation, especially if shock is not another name for too much ether. The use of whiskey or alcohol in any shape is not good treatment for an overdose of ether. The best way to employ whiskey, as a rule, is to give it by enema with hot beef-tea, about two ounces of whiskey and six ounces of beef-tea. Dry friction with the hand or with a dry cloth, especially to the extremities if they are covered with clammy perspira-

tion, will do much to bring about reaction, and also will lessen radiation from the surface by preventing evaporation of the perspiration. Morphia in small doses, one-eighth of a grain or less, is also useful as a heart stimulant and as a anodyne, if, when the patient becomes conscious there is marked pain. The morphia not only acts as a stimulant itself, but prevents depression which would result from severe suffering. So much for the immediate treatment of shock. Under ordinary circumstances, when the shock is marked and yet not so profound as to be alarming, within half an hour strychnia can be pushed to a fifth of a grain, atrophia to a fiftieth, caffein to five grains or more, and digitalis to a twenty-fifth of a grain, or what is really better, tincture of digitalis to half a drachm, with the fiftieth of a grain of nitroglycerine.

If the crisis passes and yet the patient remains in a markedly depressed state, the question of treatment for the ensuing twenty-four or forty-eight hours comes up. The use of external heat should be continued until the temperature of the body becomes normal, and even longer should the patient complain of chilliness. But the sheet anchors of safety are strychnia, digitalis and whiskey. In a marked case it is my habit to give the following order: To give hypodermically sulphate of strychnia, one-thirtieth of a grain one hour; tincture of digitalis, fifteen drops, with the one-fiftieth of a grain of nitroglycerine, the next hour; three grains of citrate of caffein the third hour; and an anema of whiskey, two ounces, and beef-tea, six ounces, the fourth hour. This order I have had carried out many times for twenty-four, forty-eight and even seventy-two hours. In the worst of cases, for its temporary effect, cocaine has been employed in addition to the above, also small doses of morphia if much pain and especially if great restlessness were present. It is my experience that most patients will take a fifth of a grain of strychnia in twenty-four hours without manifesting symptoms of strychnism. I have not employed the heroic doses of strychnia described by some writers, such as half a grain within two hours, but in a desperate case, watching it carefully, I should not hesitate to give repeated doses of one-fifteenth of a grain every half hour for a

short time until some symptoms of irritation appeared. We certainly have no more reliable exciter of the nervous and muscular systems than strychnia, nor any drug which is more capable of maintaining its effect.

Digitalis is also a very reliable drug in the treatment of shock. It is capable of whipping up the heart to increased work, especially for a few days and until a sustained effect can be secured by alimentation. This is exactly what is required in the treatment of shock. Digitalis has, however, one effect which is undesirable. It causes a contraction of the arterioles, and thus increases arterial pressure, so that while it whips up the heart to do increased work, it also hinders the heart through the increase in arterial pressure; hence, it is wise in the treatment of shock, to combine digitalis with nitro-glycerine, which overcomes this bad effect of digitalis. The combination is much more effective than either drug alone. Caffein is a pure heart stimulant, and can be administered freely without evil consequences. Alcohol used judiciously and in not too large quantities, is one of our most important remedies. In shock following abdominal operations, it is best administered by enema combined with beef-tea, which is itself a stimulant. Later in the case champagne by the mouth is often of service, but it fills only a partial indication and is not to be compared in value with whiskey when this can be ingested and retained.

The management of the diet in the treatment of shock is also important. Immediately after an operation accompanied by much shock, the stomach, as a rule, is not retentive; hence it is wise for a time in no case to administer much aliment of any description by mouth. Some hot black coffee or hot beef-tea is as much as should be given. When the stomach becomes retentive, light, easily assimilable food should be employed, as beef-tea, broth, milk (preferably peptonized), egg-nog, punch, etc. These foods should be administered in small quantities frequently repeated. The question of alimentation in the treatment of shock following abdominal operations offers certain peculiar difficulties. Under ordinary circumstances, when shock is not a special feature, it is the rule to administer no food to the patient, who has had a

cæliotomy, for from thirty-six to forty-eight hours after the operation. Then broths or beef-tea from two drachms to one ounce, or two drachms of milk with one of lime water, are given every half hour, and if retained the quantities are increased and the intervals lengthened, until about the fourth day after operation the patient is put upon liquid diet, the amount being regulated largely by the appetite. But in cases accompanied by marked shock, if the stomach proves retentive, it is wise to begin the administration of milk or beef-tea at the earliest feasible time, the quantity being increased as rapidly as in the judgment of the surgeon the patient is able to digest and to assimilate. In some critical cases lives will be saved by judicious alimentation, which would be lost were the usual rules, applicable in abdominal surgery, followed.

It may be questioned whether the term shock should be applied to conditions which persist for one, two, three or more days. It is customary to consider that shock is of temporary duration, and that it ends either in the prompt death or in the recovery of the patient. But there are cases in which it is difficult to assign a name for the condition of patients, if it be not shock. I refer to those cases in which the patient exhibits marked shock after operation, and in which, although after a time the temperature of the body becomes normal and remains so, yet the patient's vitality remains at a very low ebb, the pulse continues rapid, small and feeble. The cutaneous circulation is not restored, the surface of the body being cool and pale; and where no other symptoms are present, except those of pronounced asthænia. This condition must be called shock, or else inanition or asthænia following shock. The condition persists until it is relieved by alimentation, as the nerve and heart stimulants, strychnia, digitalis and even whiskey, are not curative. I have had patients to die in this condition as long as a week after operation, without having manifested other symptoms than those of pure asthænia, and in which the post-mortem examination showed no cause of death. On the other hand, I have seen patients recover from this condition, improvement becoming manifested upon the third, fourth or fifth day, when it had appeared that death was imminent from failure of

the heart and respiratory centres. It is in such cases that judicious alimentation is of the highest importance.

In this class of cases the administration of oxygen gas by inhalation, is at times of service. All the vital functions are at such a low ebb, that any agent which is capable of improving the processes of metabolism is of value. My experience with the use of oxygen for this purpose is limited to one case; which was one of marked shock following an operation for double pus tubes, in a woman reduced to the last extremity by hectic. She went to bed with a pulse of 180, with cool and blue skin, and every other evidence of the profoundest shock. The pulse did not fall below 145 for three days, near the close of which period there was every indication of early death from pure asthænia. The plan of treatment already detailed was followed out in her case, and in addition oxygen gas was administered during one day. It seemed to be of great benefit; at all events, she passed out of the shadow of death and made a good recovery.

Higher Medical Education.

"In pursuance of the policy recently announced in the resolution to be presented to the American Medical College Association, the trustees and faculty of Rush College have decided to require four years' attendance at College from students who began the study of medicine this year with a view to graduation in 1898; however, those who have already studied medicine one year or more with a preceptor so that the four years of study, already acquired will be completed before July, 1897, may graduate after three courses of lectures as heretofore. To encourage proper preliminary study, graduates in Arts and Sciences from high-grade colleges, and graduates in Pharmacy and Dentistry from colleges requiring a proper amount of study, and two full courses of lectures will, until further notice, be allowed to graduate after an attendance on only three courses of lectures."

— **ONE HYPOTHESIS.**—She.—"Why is it when physicians get sick they never attend to their own cases?"

He.—"I don't know, but I should say it was because they can't charge themselves anything for it."—*Life.*

OCCLUSION OF THE OS UTERI COMPLICATING LABOR AT TERM; ABDOMINAL PREGNANCY.

P. L. HILLSMAN, M. D. ALBANY, GA.

Mrs. H., aged 29; robust, well developed; married nine years. Began menstruating in her 14th year, and was quite regular until she conceived. Six months prior to conception had some form of uterine disorder, and was under the care of a physician until a short time before she missed her menses.

Gestation progressed without any unusual symptoms to full term labor; pains commenced about 1 A. M., and continued until 7 A. M., when I was called to attend her. On arrival I found the pains frequent and rather of an expulsive character. Digital exploration revealed uterus well descended into pelvic canal, with the ovoid form of a vertex presentation, but no os could be found.

After a more minute examination I detected a point somewhat depressed and more attenuated than the surrounding tissue, and being satisfied that it was the os occluded by adhesive inflammation, I proceeded to operate as follows: An ordinary uterine sound was forced through the most depressed point, this was followed by a uterine dilator, and parts expanded until the index finger could pass. Full dilatation was now gradually accomplished with the fingers, aided by moderate chloroform narcosis, and labor terminated without further assistance at 5 P. M. Child was still born, attributable to tedious and prolonged labor. Patient made an uninterrupted recovery, and has since been perfectly regular in her menses.

Remarks. The history of this case goes to show that at the time of conception she had endocervicitis, which resulted in adhesion of the parts, there being no menstrual flow to mechanically expand the os.

M. J., colored; age 42; married; has given birth to five children—last child four years ago; consulted me April 1, 1892, with a history as follows:—Fifteen months ago missed her menses, symptoms of pregnancy followed. She also thought that she experienced quickening, and made ready for the event of parturition. Having gone several months over her time without any symptoms of labor, she con-

sulted a physician, who informed her that she had uterine fibroid, and that she would in all probability get relief after her courses left her. She was comparatively well at the time and continued her vocation—that of an ordinary hand in the field—until about one month before consulting me, when, owing to feeble health, she was compelled to give up her work. The patient, at the time of her visit, was emaciated; complained of gastric disturbance said that she felt as if her stomach was not large enough to hold sufficient food to satisfy her hunger, and vomiting ensued if a moderate meal was taken. Abdomen enlarged, presenting the appearance, of pregnancy at term. On examination I found the uterus anteverted, and with difficulty passed a curved sound three and one-half inches. The tumor gave some evidence of semi-fluctuation. Case was diagnosed as ovarian cyst, possibly malignant in character, as patient had lost flesh rapidly, and the gastric disorder led me to suspect similar trouble in stomach. Operation urged, but owing to her husband being actively engaged in crop, it was deferred for the time. The patient was placed on a tonic course, and nutritive diet ordered in small quantities and often repeated.

July 1st, patient returned and insisted on the operation; stated that she had gained some strength shortly after first visit; had her menses to come on twice, and was hopeful of recovery, but for the past two weeks had begun to fail again, and vomit to her food. Operation July 4, 1892. Under strict antisepsis, abdominal incision was made from the umbilicus down near to symphysis; walls very attenuated and completely adherent to sac. After freeing adhesions on the left side, about one inch from median line a peculiar pouch was discovered, which was at first very puzzling. On further dissection, however, it was found to be a reflection or folding of the sac on itself. This was caused by a partial absorption of the liquid contents of the sac, and the resilient abdominal muscles caused an overlapping of the flaccid walls. The sac having been freed as far as the incision

would allow, a trocar was introduced and the liquid contents withdrawn. Only about one pint of thick caseous matter passed, the appearance of which rather strengthened my fear of malignancy.

Finding it impossible to bring the mass through this opening, the incision was enlarged through and above the umbilicus about four inches. Further effort was now made to free the sac from its intimate adhesions to the adjoining viscera, which being found impracticable was abandoned. The sac was now incised and to my great relief was found to contain a well preserved child weighing seven pounds. This with its shriveled placenta was readily extracted without any hemorrhage. The free portion of the sac was removed and the edges stitched to the abdominal walls. A drainage tube was placed in the abdominal cavity at the lower point of incision and the sac loosely packed with iodoform gauze. Dressing was completed with a thick wadding of iodoform cotton, covered by gauze and bandage.

The patient rallied well from the operation and began to cry piteously for food. She was allowed one teaspoonful of Wyeth's meat juice every four hours, and small quantities of crushed ice.

July 5th—Temperature 99 $\frac{1}{4}$ ° F. Slept well during the night from hypodermic of morphia. Still clamoring for solid food.

July 6th—Temperature 100 $\frac{1}{4}$ °. Allowed milk with lime water, in small quantities, and egg albumin water.

July 7th—10 A. M., found patient in collapsed state, with great pain in the bowels; abdomen much distended with flatus, more particularly over region of stomach. Breath exhaled an odor of decayed eggs. On questioning the attendant, her husband, he acknowledged that he had given her three eggs for supper on the previous night, and other things in proportion. He said he did not think she would ever get up without getting more to eat. A stomach tube was inserted and about half a gallon of offensive matter removed and the organ cleansed with warm water. Dressing was removed and the wound found in good condition; very little discharge having taken place since operation. The patient did not rally from the collapse, and died at 6 P. M. Her body was removed the same night to the country and consequently no autopsy was made.

Remarks.—The progress of this case up to the third day, led me to hope for a favorable result, and the unhappy termination should justly be attributed to the pain and distress incident to the heavy meal of eggs, etc. The condition of the wound would exclude septic poisoning as a possible cause of death.

A VERY UNUSUAL FOREIGN BODY IN THE LARYNX.*

W. H. NEWMAN, M. D.

On December 23rd, I. E., an infant ten months old, was presented at the office with the information that at noon of the 19th, she had swallowed something which "stuck in her throat."

The father was under the impression that the offending body was a part of a hickory nut. The child had no symptoms except a slight difficulty in deglutition—could nurse easily, and was as full of life and playfulness as ever.

Another physician, consulted the day previous, said that he could detect the nut, but could not extract it.

When the child ceased crying, Dr. Clark auscultated the thorax and detected an abnormal whistling sound in the larynx, which was so unusual as to favor nothing but a foreign body. Introducing the finger into the oro-pharynx, and raising the

epiglottis, an abnormality was at once felt. After several attempts to loosen the body with the finger, a pair of small dressing forceps were inserted and the body extracted. This was nothing less than an open safety pin. It was evidently astride the rim of the glottis, the pin part projecting into the oesophagus, and the fastener in the larynx. This accounts for the fact that it passed neither into the trachea nor the stomach, and that it was not coughed up, the arm of the fastener preventing.

The points of interest in the case are :

- 1st. The rarity of the accident.
- 2nd. The paucity of subjective symptoms.
- 3rd. The difficulty of diagnosis and treatment in a struggling infant.
- 4th. The value of perseverance in such cases.

* In the practice of E. Clark, M. D., Grinnell, Iowa.

SUBCUTANEOUS INFUSION OF A NUTRITIVE SALT SOLUTION IN CASES OF REFUSAL OR INABILITY TO TAKE FOOD.*

MILTON D. NORRIS, M. D.†

Although the intra-venous and subcutaneous injection of large quantities of fluid, for the purpose of keeping up the blood pressure, has long been practiced, I believe the idea of administering nutriment by subcutaneous infusion originated with Dr. George H. Rohé and was first used in this hospital.

Ilberg and Lehman in Germany, within the last year, report several cases in which good results followed the hypodermic injection of 600 cubic centimeters of a saline solution in the fasting insane, but these gentlemen used a simple salt solution without any actual nutriment.

In the cases I am about to report, the solution used was composed of twelve to fourteen ounces of sterilized water, to which, after partially cooling, was added the whites of two eggs and thirty grains of common salt. This was filtered through cheese cloth. The resulting liquid had about the appearance and consistency of simple syrup, and would coagulate on being heated. Only the whites of eggs were used, because they do not require any previous digestion, but can be directly assimilated.

An ordinary stomach tube and a medium-sized aspirating needle were the only instruments employed in giving the infusion. No force, except that of gravity, was used, and generally only one puncture of the needle was required. The loose tissue over the gluteal region was always selected as the point of puncture, and the time required to inject the fourteen ounces was never over fifteen minutes. The injection of this large quantity of fluid in such a limited area would, of course, make a considerable swelling; but this would disappear in an hour, and there was not a single case in which any bad effect followed the injection.

The subcutaneous method has the advantage over the intravenous of a gradual absorption of the fluid, and therefore no danger of overwhelming the heart, besides there is no danger of emboli or the admission of air into the veins; and this

method can be used by any one with a little care, while the intra-venous can only be used by the skillful.

The first case was M. J. K., male, aged fifty years. Case of chronic mania, who was constantly dirty, noisy and tearing. He had been fed for some time by means of the stomach tube, but became weakened and more emaciated every day. He was given fourteen ounces of the fluid at intervals of four days, and fed on the intervening days. His appearance and condition greatly improved, and on the day after the third infusion he began to eat and has given no trouble since.

CASE 2. W. P., male, aged sixty-five years. Case of dementia, suffering from Bright's disease. At time of admission his pulse was sixty-four, and every attempt to swallow was followed by vomiting. All efforts to feed by the mouth were stopped and he was given the infusion every day for four days, at the end of which time there was marked improvement; his pulse being eighty and much stronger. He was then able to retain food on his stomach, but from time to time had attacks of vomiting and after several months again became so weak that the infusion was repeated with good results.

CASE 3. T. C., male, aged eighteen years. Case of acute mania. Admitted January 24, 1893, at which time he was constantly swearing, crying or singing, and biting at every one who came near him. He was in a very weak and emaciated condition, owing to his refusal to eat for several days previously, and was fed the usual quantity of milk and eggs by means of the stomach tube, but soon vomited all he had taken, and during the next twenty-four hours was not able to keep anything on his stomach, although several attempts were made. All efforts to give food by the mouth were stopped, and fourteen ounces of the infusion given daily for three days, during which time he received no other nourishment. On the fourth day he was much stronger and perfectly quiet, pulse good, tongue clean, and complained of being hungry. He was given food, which was retained, and he ate regularly with a good appetite afterwards. This

* Read at the semi-annual meeting of the Med. and Chirurg. Faculty of Maryland, November, 1893.

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patient has since been discharged from the hospital cured, but I believe he would have died from exhaustion if the infusion had not been used.

CASE 4. A. E. C., white, female, aged fifty-two years, case of acute mania. Patient was very violent, and was fed with a stomach tube, but this had to be abandoned on account of an abscess involving the mouth and throat. She was given the infusion on three successive days, but died on the fourth day from exhaustion caused by the extensive inflammation of mouth and throat.

CASE 5. E. D., white, female, aged forty-eight years, case of epileptic insanity. The epileptic seizures occur once in two or three months, and are followed by a period of depression. During one of these depressed periods she refused all food for several days, and was given the infusion on three successive days. She improved considerably and began to eat on the fourth day.

CASE 6. R. L. T., white, male, aged thirty-one years, case of simple melancholia. This patient refused to eat, and despite persistent feeding with duck and stomach tube he became weaker and took to bed in a very weak and emaciated condition. His secretions were foul and vomiting occurred frequently. The infusion was given on four successive mornings, and although during this time, over 100 hours, he did not take any food into his stomach. His condition in every respect was better than it was before receiving the infusion; his tongue became moist and clean, pulse stronger, and his mental condition was much better. He asked for food, and has so much improved that he now has liberty of the grounds, and will most likely be sent home in a short time. This patient was discharged recovered, November 19, 1893.

It is well known to every alienist that certain cases of melancholia with refusal of food, not due to illusions will gradually emaciate and die in spite of the most persistent artificial feeding, and it is in these cases that the subcutaneous infusion of nourishment will find its greatest use.

In cases of delirium tremens where the stomach will not tolerate anything, this method affords an excellent means of keeping up the patient's strength during the three or four days that the stomach is resting; also in severe cases of vomiting.

of pregnancy, and any case where the stomach must have rest, this method of giving nourishment will be useful.

It has the advantage over rectal feeding of not being so dangerous or so disagreeable to the patient, and of being more certain in its effects, besides it stimulates the heart, and increases arterial tension which is important in cases that are very low, as most of these will be in which this method is indicated.

I believe this method of administering nourishment can be used to advantage in a considerable number of cases by both the alienist and the general practitioner.

A Four Year's Course at Jefferson Medical College.

At a meeting of the Faculty of Jefferson Medical College, held on January 8, 1894, it was unanimously resolved to institute a compulsory four years' course with the sessions of 1895-'96.

This step was taken in order that the large clinical service of this Jefferson College Hospital (350 cases a day) might be utilized to the fullest extent in carrying out the desire of the faculty to provide advanced Medical education of a practical character.

VACCINATION matinees have become quite the fashion in Paris. Persons belonging to fashionable society co-operate in arranging to have a doctor and a cow at an afternoon tea. The company are all vaccinated from the cow. In some of the large houses on the Champs Elysees, the cow is taken up in the elevator, and is temporarily installed in the dining-room. The cards issued bear the words: "On Vaccinera."—*Ex.*

IT IS reported that there are 700 women practicing medicine in the Russian Empire, and a new school of medicine for women has just been started in St. Petersburg, with a four years' course of study. To the support of this school the State contributes annually 15,000 rubles, and from one to three years' service in the hospitals for women and children is expected of the students before they present themselves for the final examination.—*Pub. Opinion.*

SOME AFFECTIONS OF THE EXTERNAL AUDITORY CANAL.*

S. G. DABNEY, LOUISVILLE, KY.

[CONDENSED.]

The most common affection of this part of the ear is accumulation and impaction of the ear wax. Frequent as this symptom is, we are yet often unable to attribute it to any definite cause. It may be due either to over activity of the ceruminous glands or to a dermatitis of the canal which prevents the passing outward of the wax as usually occurs.

Burnett has observed that persons whose sweat glands are very active are likely to be annoyed by impacted cerumen, and it has been my observation that these cases occur more often in warm than in cold seasons. Whether this is due to over-formation of wax or to its being softened and running down on the drum membrane, is open to question; but the resemblance in structure between the sweat and the ceruminous glands gives color to Burnett's suggestion, that their activity may be excited by the same cause.

An accumulation of wax is more often produced by over-zealous efforts at cleanliness than by neglect. The habit of pushing into the ear a little of the twisted end of a towel or the use of instruments of any kind in the patient's hands is much more likely to push any wax that is present further in than to remove it. The symptoms of impacted wax are so familiar as not to require mention. They are most often of sudden occurrence and very frequently are first observed after a bath, by which the wax has been so carried down as to press on the drum membrane. In such cases patient's are in the habit of saying that they have gotten water in the ear and could not get it out. It will be observed that the symptoms produced by impacted wax depend largely on the position; so long as it is loose in the canal, a considerable quantity may remain unperceived, but when pressure is made on the membrana tympani symptoms are often very annoying and may indeed be serious. A case was reported where the patient thought his ears had been effected by a stroke of lightning. An examination revealed resting against the drum membrane a mass of wax, the removal of which gave entire relief to all the symptoms.

In a certain proportion of cases the condition of the ceruminous glands seems in-

dicative of disease of the tympanum. This is best marked in the so-called proliferous or in advanced catarrhal inflammation; in such cases there seems to be atrophy of the sweat glands and patients often volunteer the statements that their ears are dry and secrete no wax. In early catarrhal disease either of the naso-pharynx or middle ear, there is said to be an over-production of cerumen. Thus it behooves us in every case of wax in the ears to search diligently for the cause, and especially to examine the condition of the middle-ear and naso-pharynx. Yet in my own experience most cases are without any discoverable cause.

Methods of removing wax need little description. In the great majority of cases the syringe and warm water properly used are amply sufficient. When there is desquamative inflammation of the canal the syringe often fails, and I find most satisfaction in the use of Buck's curettes, delicate forceps, and occasionally a small hook; but instruments are seldom needed, and should be used only by one accustomed to aural practice. One case was reported where syringing was found insufficient; a large mass in the left ear whose central portion wax, was but whose chief bulk was made up of dried skin, the result of a desquamative inflammation, had to be gradually and laboriously picked out with curette and forceps, softening it a little with a solution of bicarbonate of soda. When the wax has been removed, we often find the canal slightly inflamed, with a tendency to desquamation. In such cases a little yellow oxide of mercury ointment (gr. i. to vaseline oz. i.) is an old-established and valuable remedy. When there is much scaliness and itching, oil of Cade (oz. i. to vaseline or olive oil oz. vi.), may be used with advantage.

Diffuse inflammation of the Auditory canal, varies widely in its symptoms and its causation. Leaving out of view those cases which occur as complications of middle ear disease, we find irritation from picking at the ear with hair pins, ear spoons, etc., among the most frequent causes. The inflammation may be gouty; it is often eczematous; it is rarely diphtheritic.

Roosa states that the symptoms in the

order of their occurrence are: itching, pain, and a sense of fullness and heat. To these I would add in many cases pain in the movements of the lower jaw. Objectively we find deafness, redness, swelling, and later often suppuration. The most variable of all symptoms is pain. Its degree depends chiefly on whether the inflammation is in the cartilaginous portion of the canal only, or involves the bony also. In the latter case it takes the character of a periostitis and is often most intense. Indeed, even the agony of acute suppuration of the middle ear is not greater in severity, and is more easily controlled than that of severe inflammation in deeper parts of the auditory canal. The most intense cases of this character which I have seen, have been in ladies whose general health was debilitated. Next to pain the deafness and itching give most annoyance. The former depends on the obstruction and varies with the degree of swelling; the latter (itching) is usually the first symptom, and the rough means used to relieve it by the patient often greatly intensifies the inflammation. Occasionally there is a mastoid periostitis complicating disease of the canal. It is manifested by the usual symptoms, but need not give the same anxiety as when it attends disease of the middle ear, as the inflammation is almost always confined to the periosteum.

In the treatment of this disease we, of course, look first for any constitutional cause such as gout, syphilis, etc. As regards local treatment: There are two points as to which experience seems to differ greatly. They are the use of poultices and the value of early incisions. It is contended by many eminent aurists that continued poulticing gives rise to granulation tissue, and does more harm than good. Thus Roosa says,—“A poultice should never be applied to or on the ear for more than a few hours. They are almost as dangerous a remedy in aural as in ophthalmic practice, etc.” I have not found this the case, except when used after an incision or the opening spontaneously of an abscess. For the relief of pain and to subdue swelling, there is in my experience no substitute for the poultice, but when there is free discharge it should be discontinued. Next in value to poulticing is hot water allowed to run into the ear from a fountain syringe. The piston syringe should not be used; its force is painful. It is often well to use

the poultice and hot water alternately. A salve of cocaine, menthol and carbolic acid I have found of some service in allaying the pain and itching. Of course when there is free discharge the first indication is thorough removal of this. In such cases application of nitrate of silver gives the best result.

As regards incisions into the swollen tissue: I have found them useless except to evacuate pus. The circular shape of the auditory canal holds the cut surfaces constantly in contact and prevents the relief that might elsewhere be obtained from the lessened tension. When the incision is to be made, a few drops of a four per cent. solution of cocaine should be injected hypodermatically—the syringe being used through a good sized speculum. A curved bistoury is the best instrument for the purpose, carried in over the point of greatest tension and cutting outward. With the use of cocaine this little operation is almost painless; without it, intensely painful.

In obstinate cases a blister on the mastoid is sometimes useful. Leeches, invaluable as they are in acute suppuration of the middle ear, have but little control over inflammation in the auditory canal.

I desire to report one case recently met with in practice, in connection with the paper. The patient was a gentleman about fifty years of age, who this summer had an attack of erysipelas affecting the auditory canal of the left ear. I did not see him in that disease, but did see him about four weeks after his recovery. I found the canal inflamed and swollen, and there was a slight discharge. I tried first, nitrate of silver and later all the well-known routine remedies. Although there was swelling, I did not believe there was any pus to be evacuated. I applied a blister behind the ear, as this sometimes produces a favorable result. Also used Fowler's solution internally, without effect. Finally I made an incision into the auditory canal, and without my advice the patient used hot applications for a while afterward. The result of hot applications following incision, was growth of granulation tissue in the canal. The patient left the city shortly after this and I have not seen him since. I report the case simply to show the obstinacy of some of these affections of the auditory canal; they are not dangerous yet, as this case shows, they are sometimes exceedingly tedious.

CHRONIC RETRO-BULBAR NEURITIS.

W. CHEATHAM, M. D., A. B., LOUISVILLE, KY.

[CONDENSED.]

The true pathology of this affection was not well understood until the first demonstration in an autopsy by Samelsohn, in 1882.

Leber, Michel and others had referred to it before, but had never demonstrated the fact by autopsy. It has been demonstrated "that the marginal fibers of the disc ends in its immediate vicinity, and, in general, the central fibers go to the periphery of the retina, while the peripheral fibers of the disc supply the central part of the retina; the papillo-macular fibers entering the eye as a wedge-shaped cluster on the temporal side of the disc occupying nearly its inner and lower quadrant."

As the title of the paper implies it is only the fibers of the optic nerve in front of the chiasm that are involved generally.

Causes: The principal cause is alcohol or tobacco, alone or combined; some authors say it is tobacco alone, the alcohol acting only as a depressant. Of 138 cases, 64 were from alcohol, 23 from tobacco, 45 from tobacco and alcohol combined, diabetes 3, lead 1, and sulphuret of carbon 2; other causes as cold, and especially cold blasts on the face, chloral, stramonium and syphilis are given by Swanzy.

Symptoms: The failure of vision is so slow usually that the patient does not discover it until it is well advanced. Only this week, a man came in with tobacco-alcohol amblyopia, whose vision was but half of perfect. The patient complains of seeing as if he were looking through smoke or a veil. The vision of the two eyes is usually about the same, which is a point in differentiating it from disease of central origin. In the beginning there is no trouble with the field of vision; later on though, there will be discovered a central negative scotoma for colors, especially green and red. This scotoma is usually oval in shape with the long axis horizontal.

The retina involved being that portion extending from the temporal edge of the disc to the outer edge of the macula. Later on the perception of white will diminish in this area, and if the disease progresses may be entirely lost. Vision is

often reduced to almost nothing in this affection, but total blindness is exceedingly rare.

It is not the periodical drunkard who is liable to suffer from this trouble, but the sipper, or steady drinker, or more often the fellow who never gets drunk. The disease is more common in the male than the female, in the old than the young, for reasons easily understood. Some author has stated that it does not occur in persons under twenty years of age, yet I have a patient now only sixteen years old; cause, the abuse of tobacco and beer.

A peculiarity of the disease is that a person may be nearly blind from tobacco-alcohol amblyopia, who under treatment may recover vision, then return to his old habits, and exceed even the abuse formerly practiced, and yet have no relapse.

The ophthalmoscopic symptoms, especially in the early stage of this disease are usually negative; the optic disc may be a little hyperæmic, or present what I used to call a brick dust color and granular appearance; later on the temporal half of the disc becomes quite pale. A point in differential diagnosis I have seen made somewhere, just where I cannot now recall, is that by the inhalation of a little amyl nitrite, vision is much improved for a while. I tried this last week on a gentleman about sixty years of age, whose vision was only $\frac{1}{2}$ of perfect, the result of alcohol and tobacco abuse, especially the latter. I told him to look at the test card, and passed under his nose a glass stopper with a drop or so of the amyl nitrite on it, and he immediately exclaimed with much joy that he could see as well as ever. He demonstrated the fact by reading $\frac{1}{2}$ or more than required in a test for perfect vision. How long this lasted I do not know as I have not seen him since. Strychnia hypodermatically in a large dose may have the same effect.

The pathological changes, as given by Samelsohn and others, in the optic nerve consists in an interstitial neuritis at its axis, commencing outside of the chiasm, preferably this portion of the nerve, and

leading to proliferative of connective tissue, and to secondary atrophy of a certain bundle of nerve fibers; the changes are analogous to those which take place in the liver and brain as the result of chronic alcoholism.

Treatment: The first indication is, of course, to correct the cause; promises to do so are easily gotten and as easily broken. A majority of the cases, if not too far progressed, will recover with no other treatment than the

correction of the cause. Again others will need the leech, turkish bath, and strychnia; the latter preferably hypodermatically. I usually order strychnia nitrate gr. iv; aqua, ounce one—each drop contains gr. $\frac{1}{16}$ of the strychnia. I commence at gtt. ii, and increase one drop per day until the physiological effect is reached, which may be anywhere from gtt. xv to gtt. xl. Pot. Iod. is indicated also, or I often give zinc phosphide and strychnia, in pill,

CASE OF PARALDEHYDE HABIT.

T. H. STUCKY, M. D., LOUISVILLE, KY.

I would like to report a case of paraldehyde habit. The latter part of April I was called to see a young woman twenty-one years of age, who had previously been addicted to the use of morphine. She had been in Illinois attending the Keely Institute and had been relieved partially. I found her very restless and nervous, and prescribed valerian and assafetida, but she was unable to take it. I then ordered three ounces of elix. paraldehyde, (Flexner), saw her the next [day, when she seemed much better, and told her if she had any further trouble to let me know. I heard nothing more in regard to the case until, I think, the latter part of September, when her husband came to me and asked if his wife could not stop taking that stuff; that she had had the prescription doubled in May and filled ten times—which was sixty ounces; in June had it filled sixteen times—which was ninety-six ounces; in July filled twenty times—making one hundred and twenty ounces; in August filled twenty-three times—one hundred and thirty-eight ounces; September filled thirty times—one hundred and eighty ounces.

I went to see the patient and she stated that she drank the medicine from the bottle whenever she began to feel a little faint or nervous. I was surprised to learn that it still produced sleep and gave her decided benefit apparently, but the most interesting feature was, that I could not see it affected the heart to any marked degree. It produced absolutely no alarming symptoms, and her appearance was similar to

what we see in a person addicted to strong drink—she resembled an individual who had been on a protracted spree. The paraldehyde was withdrawn the first of October entirely. She was placed in bed and watched carefully by a competent nurse, and I gave her valerian and strychnine. She seems to suffer just as one who is recovering from delirium tremens.

This patient consumed an average of six ounces of paraldehyde a day, or one hundred and eighty ounces during the month. I have never seen report of a case of this character and it struck me as being very unusual.

ONE OF EX-SENATOR EVARTS'S STORIES.—To Mr. W. M. Evarts belongs the anecdote of the bereaved widow whose husband had such a large circle of friends that the company which she received on the evening of his interment crowded her drawing-room almost to suffocation. A lady friend of the widow edged her way up to her, and, pointing to something very bright and shining visible above the heads of the assembly in a remote corner of the apartment, whispered in her ear, "Say, is that a new eight-day clock? What d'ye gin for sich?" "It's not a clock," sobbed the disconsolate widow: "It's the dear departed. We set him on end to make room for more company." The supposed eight-day clock was indeed the "casket," richly ornamented with silver nails, bosses, and handles, to which the dear departed had been consigned.—G. A. SALA, in *London Telegraph*.

RETENTION OF URINE WITH HÆMATURIA.

OSCAR LEEDOM, M.D., PLYMOUTH MEETING, PA.

J. D. A large, powerfully built man, about fifty years of age, was taken sick with retention of urine on the 18th day of November, 1892. He had been husking corn and was on the damp ground from early in the morning until late in the evening. During the four succeeding days he managed with great difficulty, to pass a little urine, but continued at his work until the 22d, when the retention was complete, and he sent for me.

I found the patient in great distress, unable to pass a drop of urine, and the bladder tremendously distended. Upon introducing the catheter I drew off a great quantity of urine. From this time on, he had no control of the bladder whatever, the catheter having to be used twice daily. There was no pain except when the bladder became distended with urine; no tenderness upon pressure, nor any burning along the urethra.

He continued in this condition about two weeks, when, suddenly, his urine became bloody and he began passing great quantities of jelly-like mucous. This was accompanied with intense burning and distress. The pain grew severer as the bladder became empty every time the catheter was used. The urine was reddish-yellow or bright-red, at times followed by the discharge of nearly pure blood with the last few drops of urine. This continued about five days, when the urine began to clear up, the mucous disappeared and the urine returned to its natural color. The pain and burning ceased and he seemed in a fair way to recover.

A day or two after, however, the same symptoms returned in all their former intensity. The urine became bloody, filled with mucous, and loaded with shreds which looked like exfoliations from the mucous membrane of the bladder. The burning and distress returned. In a few days the urine again cleared up, to be followed by a similar recurrence after an interval of a few days. So long as the urine remained clear the patient was quite comfortable, slept well, and was comparatively free from pain. The retention still continued, necessitating the use of the catheter twice a day.

He continued in this condition until the 20th of December, when he began passing urine in the natural way. Dec. 24th. "Passed urine without much difficulty. Urine slightly cloudy from presence of small quantity of mucous. No albumin; clears up upon boiling." (The urine was not examined at any time with the microscope.)

This case was of considerable interest to me, and presents some remarkable features. The diagnosis was not clear. I feel positive that the hemorrhage was vesical, but the origin of it was not at all clear. Coming on as it did so suddenly, stopping and then recurring, to eventually cease with the return of health. The presence of a tumor, either villous or malignant, seems out of the question. There was no history of malaria, and the absence of pain or tenderness upon pressure over the region of the bladder, seemed to exclude any serious inflammation of the mucous membrane with ulceration or necrosis. The prostate was not enlarged to any extent. *From Hemorrhoidal Clues*

The treatment consisted in washing out the bladder twice daily, with warm solution of boracic acid and injecting a solution of glycerole-pepsin, the object being to dissolve the jelly-like mucous which came away in great quantities. Internally ergot and ex. uva-ursi were given, with morphia to relieve pain. The patient recovered entirely and has never suffered any bad effects from his illness.

THE nationality of Pasteur's patients is an interesting item. France and Algeria sent him 1,584 in 1892, and Algeria is notorious as a source of supply of bitten persons. Portugal sent 96, England 26, Belgium 11, Egypt 12, Spain 14, Greece 19, Russia and the United States 1 each, Holland 14, Switzerland 3 and India 9. In Russia and elsewhere, I fancy, they have institutes of their own for the practice of Pasteur's treatment. From Madeira one patient came, his injury arising from a rabid dog which had been bitten by a Portuguese dog. Till then rabies was unknown in Madeira.—*Illustrated London News.*

THREE CASES IN SURGERY.

C. S. COPE, M. D. IONIA, MICH.

CASE I.—I was called March 31, 1890, to treat a fracture of the elbow, and found a patient with the following remarkable history: In 1820, while he was a young man of 21 years of age, he was engaged in chopping in the woods of the Empire State. Unfortunately an ax slipped from the hands of a fellow-woodsman, and inflicted a severe wound on the dorsal aspect of the left arm, nearly severing it at the elbow.

After suffering much at the hands of many doctors, he finally recovered, but with a stiff arm, obtusely flexed at the elbow. By use of shoulder and wrist, he was again able to handle his ax. But for seventy years he went through life thus maimed.

At the time I was called, he had met with an accident. By slipping on the floor in a store, whither he had gone to make some purchases, he had fallen heavily, his weight coming on the crippled elbow, producing a complete fracture through the joint. Careful attention was given, but the bones did not unite. He made much complaint of the doctors of the present time, and lauded to the skies the good old doctors of the past.

But, lo! a change came over the spirit of his dream, when, after the pain and soreness were gone, he found that he could bend and extend his arm. It was with difficulty we convinced him of the fact that, instead of a return to natural conditions, we had simply a false joint, made so by the non-union of fractured bones. It was amusing to see him raise the left hand to his head and stroke his face, a privilege he had been debarred from for so long. He lived two years after that in the enjoyment of his new elbow and passed away last winter at the advanced age of 93 years.

CASE II.—On the 13th of September, 1891, I was called to see Rachel P., an old lady of 89 years, who had fallen from a porch, and sustained a transverse fracture of both bones of the right forearm, two and a half inches above the wrist. Being thin in flesh, the fragments of fractured ends easily movable and the crepitus and deformity very distinct, the diagnosis was made at a glance.

The fracture was reduced at once, roller bandage applied, and with other indicated treatment she was quite comfortable.

The patient was demented and had been so for many years. This made it difficult to keep the limb in proper position, for she would at times loosen and remove the bandages. Finally we were obliged to muffle the well hand, to prevent further trouble. We gave it as our opinion that the bones would not unite, owing to her extreme age. But to our surprise, provisional callus was thrown out, and the bones made a complete union.

There was no doubt of this, for after six weeks she would, unaided, rise from her chair by placing the right hand on a table and bearing heavily, assume the erect posture.

But on December 13th, just three months from the date of the injury cited, the fracture was put to a crucial test. Wandering aimlessly about the house she came to the cellar door. This she pushed open with all her force. It opened inward, and giving way from her pressure, she was precipitated headlong down thirteen or fourteen steps to the depths below. Her groans brought speedy help, and the doctor was called in haste.

We found the right shoulder dislocated, while scalp and skin wounds and bruises were numerous. In fact, it seemed as though scarcely a part of the surface escaped contusion, but strange to relate, the fractured arm came out all right, although it was evident that this was the one advanced to save her as she fell.

The dislocation was reduced and the wounds attended to. She made a good recovery from the shock, and did nicely for two weeks, when she was seized with the grippe, to which she speedily succumbed.

CASE III.—On the 19th of January, 1892, Mrs. —, was walking briskly over a broad stone sidewalk which was encrusted with ice. Her feet slipped, flew skyward and she struck heavily on her right hip. The fall was a bad one, and she was severely injured. Woman like she scrambled up, and looking to see if any one had observed her mishap, went on to her destination, and returned to her father's office

in the next block, to reach which she had to ascend a long flight of stairs. She was very pale and suffered great pain whenever she attempted to walk.—We must go back a little and state that just before leaving the office, her husband had made her a present of a new lead-pencil, which he had nicely sharpened. This pencil was carried in the pocket of the short coat she wore at the time of the accident.—When she reached home that evening she found blood on her underclothing. There was a circular wound in the skin about the centre of the buttock on the right side. The clothing was also found to be perforated in places. A hole was also found in the pocket of the coat. One half of the lead-pencil was found in the coat pocket. This piece of the pencil looked as if it had been forcibly broken in two, as the end was splintered and irregular.

Search was made for the missing piece, but it could not be found. Supposing that it was in the wound, a physician was called, but could afford no relief, as the patient was nervous and apprehensive, and would not allow a thorough examination to be made.

The following evening I was called to take charge of the case. The patient had been walking around aided by crutches, and had thus caused considerable pain and distress.

By use of cocaine the wound was made painless, and a probe was passed to the depth of five inches. The wound was to the inner side of the trochanter major, nearly over the hip joint. The probe entered this and passed inward and upward toward the dorsum of the ilium.

The patient would not consent to chloroform, and was too nervous to undertake an operation without, so proceedings were stayed. We could only bide our time, and, departing, left word to recall us when she was ready to have it removed.

After much suffering, and when the wound began to discharge and smell bad, we were again summoned, and on the 11th of February relieved her of a piece of large-sized lead-pencil, three and three-fourths inches long. We had to carry the knife two inches deep to reach it, and make the wound sufficiently large to explore it with the finger, when the pencil was at once located and easily withdrawn.

Its sojourn of twenty days had sufficed

to remove nearly all the paint from the pencil. There was considerable discharge of ill-looking, offensive pus.

The wound was injected daily with Marchand's peroxide of hydrogen, and the patient made a rapid recovery.

Preservation of Leeches.

A subscriber writes that he received some leeches on one of the coldest days of the present winter; when he opened the container, he found them frozen stiff. He then put them into cold water, which apparently brought them to, as at the date of writing they were "lively." He now wants to know whether they will bite and draw when used. It is said that extremely cold weather sickens the leech and makes it inactive. The most satisfactory way for you to decide the question perhaps would be to make a trial with one or more of them. The following directions for the preservation of leeches may give you some information on the subject: As soon as the leeches arrive from the dealer, they should at once be removed from the box, and washed thoroughly in soft water, which should be at 60° F. The first washing rejected, they should then be placed in a jar half filled with water about the same temperature, with a piece of clean matslin placed over the mouth of the jar and covered with a perforated lid. Care must be taken that the water replaced be no colder than the water rejected or thrown away. The jar should be well cleansed inside every day or two in winter, and every day in warm weather, thus preventing the accumulation of any foreign matter along the sides of the jar, and the leeches taken out and gently rubbed between the fingers, or between the folds of a soft cloth to free their bodies of the mucous or slimy substance which envelopes them. You should guard also against the access of acrid vapors which may come in contact with the jar, such as ammonia, gas, and the vapor of mineral acids, which by their density finds a ready means of access through the porous lid to become absorbed by the water in the jar, which, after a short time would result fatally. If these precautions are carefully taken the leeches may be kept in a fine state of health, and there would be no likelihood of trouble in getting them to bite readily when applied to any part of the body.—*Pharm. Era.*

TRANSLATIONS.*

ACUTE RETROGRESSIVE MUSCULAR ATROPHY.

Dr. Adam Kilwicz (*Prag. Med. Woch.* 1893) says: "All forms of muscular atrophy, either of myopathic or nervous origin, finally tend toward one end—death after a longer or shorter period." The author reports one case in which he shows that the myopathic form is occasionally able to take up a retrograde metamorphosis and end in a cure.

The patient, set 28, having passed a healthy childhood, was never neuropathic; suffered during her third pregnancy with a grave attack of hyperemesis, making it necessary to feed her per rectum, since her stomach refused to retain anything. One day she had the misfortune to fall from a chair upon which she was sitting; she was unable thereafter to make the slightest movement.

A careful record shows that she was attacked by acute muscular atrophy of the myopathic form, having the peculiarity that the atrophy did not confine itself to the upper (*typus facio-scapulo-humeralis*) or to the lower (*typus femero-tibialis*) extremities alone, but attacked upper and lower at the same time. The muscles of

the balls, and all extensors, and, above all the min. peronsei were included.

It was quite interesting to note that as soon as the comparatively easy labor had been completed, a decided improvement took place; the contractions of the antagonized muscles became daily less, and slight movements of the affected muscles became possible. On the fifth day after parturition the patient was able to sit up; on the eighth day she could support her weight standing, and after the second week was able to walk with some assistance.

After the lapse of a few months the only traces of her illness left were the condition of the balls of the thumbs and the atrophy of the interossei muscles of the hand.

The author believes that the changes necessarily following in a pregnant uterus, proved the main factors, together with the lack of assimilation of nutritive principles, in producing the attack of muscular atrophy. This can, however, be explained only under the head of reflex actions.—*Centralb. f. d. Med. Wissen.*, 93.

—W.

THE TREATMENT OF PRURIGO BY MEANS OF MASSAGE.

Dr. R. Hatschek, Vienna, (*Arch. f. Dermat. u. Syph.* 1893, xxv., p. 931), reports the result of eleven cases treated after the method described by Murray. Seven of these belonged to prurigo agria, and four to prurigo mitis.

The proceeding consists of simply rubbing the affected area, beginning at the peripheral end of extremities and rubbing toward the centre. The time required for one treatment, during the first few days is from ten to fifteen minutes. As improvement takes place this may be reduced to from five to three minutes. In all cases this treatment was followed by prompt relief of the troublesome itching, and a

visible improvement in the infiltration of the skin.

In some cases there was a return of the small nodes, which, however, disappeared promptly after the vigorous use of massage. Two to three weeks seemed to be sufficient to produce a complete disappearance of the disease; while an occasional use of massage seemed sufficient to prevent a return.

The cases in which eczema formed a complication, massage appeared to act as an aid in its cure.—*Central f. d. Med. Wissen.* Nov., 1893.

—W.

The autopsy in the case of Prince Alexander of Battenberg showed that the original cause of his illness was the lodging of a cherry stone in the veriform appendix.—*Pub. Opinion.*

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators M. B. Werner, M. D., and W. A. N. Dorland, M. D.

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SATURDAY, JANUARY 20, 1894.

EDITORIAL.

TUBERCULOSIS IN ITS RELATIONS TO THE PUBLIC.

During the meeting of the Pan-American Medical Congress last September, the Section of Hygiene and Climatology unanimously adopted resolutions urging upon the governments of the nations represented, the necessity of enforcement by public authorities of measures directed to the limitation and prevention of tuberculosis. As might be expected, in view of the active public consideration of preventive and sanitary questions excited by the imminence of a cholera epidemic, these resolutions widely attracted attention among health authorities. Recently the State Board of Health of Michigan has announced that it will enforce throughout the whole state, the registration of tubercular cases and the disinfection of the dwellings and surroundings of sufferers from this disease. The Board of Health of the City of New York had already adopted the same precautions. Immediately after the adjournment of the Pan-American Medical Congress, the Philadelphia County Medical Society, with due deliberation and after a full discussion, formerly endorsed the judgment of the Section of Hygiene and Climatology, and

appointed a committee to urge upon the Board of Health of Philadelphia, the requirement of registration of tuberculous patients and the disinfection of apartments occupied by such cases, after the removal of the occupant. The matter attracted considerable public notice and afforded the daily papers an opportunity for the display of their scientific acquirements. It likewise afforded a few individual members of the city profession a chance to expose the incapability of the congregations of alleged experts, known as this or that section or society, while posing themselves before an admiring audience. The resolutions of the County Medical Society have gone into retirement, nor has any action been taken by the Board of Health. The presumption is the officials are studying up the matter with the aid of the lexicon and the quiz-compile.

The recommendation of public measures for the limitation of tuberculosis is receiving the careful consideration of health authorities of all parts of the United States, and there is good reason to hope that some public precautions will be enforced in every

state in the Union, perhaps, at no distant day.

It cannot be entertained for a moment, that the action of the section of the Pan-American Medical Congress, the Philadelphia County Medical Society and kindred associations of medical men of the highest intelligence and scientific knowledge, was taken with any undue haste or without thoughtful consideration of the difficulties and inconveniences involved, without a full knowledge of the necessity of some practical precaution, or without deliberate determination to succeed eventually. The movement for the public limitation of tuberculosis is neither a sensation nor a fad. It is the inevitable outcome of the indefatigable spirit of research carried on with experiment and observation, by trained minds with all the modern appliances of precision at their disposal. It is not the dictum of any one observer supporting a theory, or of any small number of observers engaged in upsetting theories, but it is the consensus of opinion of medical scientists slowly crystallizing from the experiences and observations of all science.

It is not claimed that our knowledge of tuberculosis is complete—far from it; but the last dozen years have shown a marvelous amount of exact knowledge acquired by scientific experimentation and most minute observation, with the resultant accuracy of conclusions. In the realm of medical science, perhaps no demonstrations have been more conclusive than that tuberculosis is an infectious disease, whether it occurs in man or other animal, and that tuberculosis is practically never directly transmitted through heredity.

It now seems ascertained that heredity plays no part in the development of human tuberculosis, save the possible transmission of an increased susceptibility to the disease, which must, however, arise from specific infection after birth. Furthermore, it is not possible for tuberculosis to develop in the human

system, no matter what the degree of susceptibility may be, without the introduction of the specific infection. There is no doubt that, as a general rule, repeated exposures to infection and a degenerate condition of the tissues invaded by the infectious material are required for the development of the disease. Almost any tissue in the human body is liable to invasion by tuberculosis in one form or another.

The lesions of tuberculosis are invariably associated with and probably caused by the local irritant action of a specific bacillus. This, the tubercle bacillus, is endowed with high vitality and great irritant qualities, though even under favorable conditions they multiply relatively slowly. While they have been cultivated artificially outside of the body, it is very sure that natural external conditions favorable for their reproduction are rarely or never present, but there is abundant proof that their virulence and power of propagation can remain latent for an indefinite time under these same external conditions. The discharges or secretions of tuberculous patients contain these bacilli in enormous numbers and constitute the media of infection. The bacilli do not occur either in the expired breath of a tuberculous person or in the exhalations of the body. So long as the secretions and expectoration of tuberculous persons retain moisture sufficient for cohesion there is no danger of infection. The bacilli cannot separate themselves from the medium containing them. But let these secretions become dried and pulverized and mingle with the dust of the atmosphere, and the tubercle bacillus has opened up to it an infinite field for operation.

This is the matter in a nut shell. Everything that comes in contact with a careless or ignorant tuberculous patient may become thoroughly infected and, in more or less degree, a constant

source of danger to those who associate with him. And when for any cause the dwelling of a tubercular case is vacated the source of infection remains in the dwelling to menace the life of future inmates unless the destruction of infectious material is accomplished by thorough disinfection. Recent researches by Dr. Flick of Philadelphia, made, in a most thorough and scientific manner, prove beyond peradventure that in dwellings known to be infected, family after family occupying them in turn, have suffered unusually from tuberculosis.

Concerning the proposed measures for limiting and preventing the spread of tuberculosis, *The Dietetic and Hygienic Gazette* for the current month says editorially:

"In so far as the propagation of the disease from man to man is concerned, the means of safety are simple, reliable and practical; but they involve the necessity for the honest and willing co-operation of the sufferer, his attendants, his physician, and the local board of health. The watch-words of safety are *registration, disinfection!* Destroy the infectious discharges at the earliest possible moment; never allow them to become dry.

Thoroughly and periodically disinfect and cleanse the apartments occupied by the sick—disinfect, before washing, his bedding and clothing, especially the handkerchiefs. After the apartments or dwelling occupied by a consumptive are vacated, either by death or removal, thoroughly disinfect and cleanse them before they are occupied by others. It is not our function to elaborate this fundamental principle of disinfection, nor have we space here to discuss its details. These, as well as other precautions, should be left to the intelligent family physician and the board of health. Anything like quarantine or restrictions of liberty of movement of consumptives, is entirely out of the question, and would, moreover, be quite impossible. On the other hand,

to instruct the attendants as well as the patient in the importance and the mode of disinfection of the infectious discharges necessitates no hardships and need add nothing to the discomfort or mental anxiety of the unfortunate victim. Indeed, so soon as the consumptive becomes convinced of the absolute necessity to promptly destroy the expectoration, the chance of the individual's recovery is that moment materially brightened, for then the constant danger of repeated auto-infection is gone. What well-informed physician does not know that the disease, already at work in the lungs of his charge, is liable to spread by further infection through constant inhalation of dust carrying tubercle bacilli already thrown off from the very same lung? What experienced physician or pathologist does not know that to cough up sputum from a tuberculous lung and to swallow it instead of expectorating is to enhance the danger of engraftment of an abdominal tuberculosis upon that which already exists in the lungs, and make both more certainly fatal? Down, we say, with the puerile and senile cant we sometimes hear in opposition to registration and disinfection for the limitation of human tuberculosis! It is injurious alike to the suffering patient and to the general public.

A practical, judicious application of modern knowledge concerning the nature, mode of dissemination, prevention and management of tuberculosis would minimize the terrors and dangers created by it. This mortal enemy of man, although he has decimated our race for ages, is not a hereditary conqueror. We have at last learned his tactics and stratagems, and have discovered the armor which renders his shafts harmless and the arms by which he can be routed. We can also cover those already wounded with an aegis of protection which will save many even of them from death. Should we longer hesitate to put on this armor and take up these arms in defense of mankind?"

ABSTRACTS.

THE ERECTILE TISSUES—THEIR PHYSIOLOGY, PATHOLOGY, AND TREATMENT.

Dr. J. J. Caldwell (*Charlotte Med. Jour.*) says: There are certain parts of the body, male and female, which, when excited, become swollen and turgid with blood and firm to the touch. The sensibilities, and indeed all of the actions of such parts appear exalted when in a state of erection. The most peculiar phenomenon in this state is the sudden and remarkable accumulation of blood in the erectile tissue at the time and as the immediate cause of the erection.

This action was formerly explained by the existence of a certain force peculiar to erectile tissue called "nervi-erigentes;" but the researches of later physiologists have discovered a peculiar mechanism in the tissue itself, by means of which the elongation is produced, viz: it depends upon pressure exercised on the veins or sinuses of the tissue by certain bands of muscular fibres; and hence the accumulation of blood as the arteries convey it freely and rapidly to the tissues. These muscular bands are supplied by nerves in much the same way as the vessels from centres located in the spinal cord, and are often called the "nerve-erigentes." But no matter whether the congestion is produced by the action of the vaso-dilator or the vaso-motor apparatus, or by direct or indirect action on the muscular apparatus of the erectile tissue, we must in any case refer any influence transmitted to the parts in question to the spinal cord. This leads us back to a genito-spinal centre in the cord, vaso-motor, but as we have seen before, no nervous centre can act of its own motion, or originate action *de novo*, they must be excited to action. This being so we must look about for a suitable excitant influence to act upon the vessels so as to cause, in one way or the other, congestion. For a long time it has been regarded as probable that the spinal cord has a direct influence on the organs of generation; but it was Budge who made the definite experimental observation in regard to the influence of the lower part of the spinal cord on the motions of the generative organs. He

laid bare the spinal cord in a male rabbit and at the same time exposed the testicle, the *vas deferens* and seminal vessel of one side. By irritating the exposed lumbar portions of the cord he found in numerous experiments that irritation of that part which corresponds to the fourth lumbar nerve produced active motions in the *vas deferens* and seminal vessels, the motion beginning at the testicle and being propagated toward the corresponding seminal vessels. The irritation on no other part of the cord produced such effects. These observations on the male, which have been often repeated with the same results, have also been made on the female; and movements of the uterus have been excited from corresponding points of the cord, therefore, the development and escape of the seminal fluid and graafian vesicle are attended with no small degree of nervous excitement. Actuated from the same spinal centre, both male and female, organs of generation becomes more and more congested and irritable as these phenomena increase, so that every impression, even every influence affecting these parts must be reflected to and from the spinal cord, from these to the brain and to the external genitals; hence we may readily perceive the relations existing between potency and the vaso-motor tonus of the genito-spinal centres, or impotency and the plexuses of these centres. In the latter case there could be no erection or there would be a great loss of the fluctuating powers of the genital organs, i. e., enfeeblement of secretions, erections and ejaculations of the male and a want of activity and ovulation and menstruation on the part of the female. Hence, all of the procreative powers are more or less dependent upon the aforesaid vaso-motors. The inhibitory action exerted by these sensory centres throughout the cord play a vitally important influence over the circulation, viz: periodical and rhythmical action of the heart and respiration, blushing, rage, pallor, and suffusion. Says John Hunter: "There is not a natural action of the body, whether voluntary

or involuntary that may not be influenced by the peculiar state of mind at the time."

Impotency in man may be caused by absence, want of development, malformation, or mutilation of the penis; by mental influence, any violent emotion operating protractedly or during coition, as want of confidence, fear of consequences, anxiety, grief, disgust, over excited desire.

By fevers and other severe diseases, the sexual organs remaining feeble after general health is restored. By injuries to the back part of the head from falls, blows, concussion, etc.; these being generally incurable, loss of power and wasting of testes and penis follow. By injuries and diseases of the spinal cord, which remove the power to copulate though desire remains and semen may be secreted. By excessive use of tobacco, which impairs digestion, and weakens nervous and muscular systems. Opium eating is injurious in like manner and from the same cause. By abuse of the sexual functions, removing the power of erection. Onanism or excessive sexual intercourse. Spermorrhœa. Impediments to escape of semen, such as stricture of urethra in which the ejaculated fluid regurgitates into the bladder. Abnormal openings in the urethra (hypospadias and epispadias) so that the semen is not ejaculated into the vagina. By excessive obesity and large scrotal hernia.

Impotency in women may be due to firm adhesions of the *labia pudendi*; excessively developed and persistent hymen; absence, malformation, or an impervious condition of the vagina; obliteration of this canal through inflammation. A double vagina impedes but does not prevent copulation. Super-sensitivity with spasmodic closure of the vagina (vaginismus). Tumor of the vagina, or uterine tumors which have passed into the vaginal canal. Elongation of the cervix uteri; engorgement or induration of *labii uteri*; obliteration, obstruction, or great narrowing of os uteri or cervical canal. Closure of uterine cavity by tumors, cancers, etc. Malposition of the uterus. Acute retroflexion and ante-flexion. Inflammation affecting the uterus. Occlusion of the fallopian tubes, disease of fimbriated extremities. Irremediable procedentia of the uterus. Large recto-vaginal or vesico-vaginal fistula, or complete rupture of perineum allowing improper escape of

seminal fluid. Uterine cancer, even when the vagina is involved, impedes but does not prevent intercourse and fecundation.

Sterility in man arises from certain diseases, such as tuberculosis, diabetes, albuminuria, some forms of obstinate dyspepsia; in advanced stages the secretion of seminal fluid is usually stopped. Some cerebral defect, owing to which the functions of the testicles have never been called into play. Disease of testicles, tumors, cancers, repeated attacks of varicocele, though as only one gland is usually affected, these conditions scarcely produce sterility. Malposition of testes, these organs being retained in the abdominal cavity copulation being feasible with the cryptorchis, but the semen ejaculated being destitute of spermatozoa. Obstructions in the excretory ducts of the testicles; such as temporary or permanent obstructions after epididymitis, with power of copulating, but ejaculated fluid being destitute of spermatozoa. Obliteration of ejaculatory canals from abscesses near prostate leading to atrophy of the testes. Abuse of tobacco, opium, and alcoholic drinks, and syphilitic taint as well, may destroy vitality of spermatozoa.

Sterility in women arises from amenorrhœa; from exhaustion or excessive general weakness; too frequent or imperfect sexual excitement, and those versions, displacements, congestions, hysterias, paralyses, tumors, which are the prolific results of masturbation. Absence, arrest of development, or disease of ovaries, only occasional, not absolute cause, as both glands are seldom diseased at the same time. Leucorrhœa, especially when the discharge is abundant and acrid, by causing destruction of the spermatozoa before they reach the ovule. Syphilitic taint occasionally destroys vitality of ovule. In the absence of all obstructions or indications of disease, with apparent perfect moral and physical adaptability, there are cases of sterility still existent, regrettable and baffling, which if not irremediable, their hope and succor rests solely in the studious skill of the neurologist. How momentous a medico-legal precaution may be the services of such an expert in family imbroglios, dubious and unjust dismemberments of estates, prevented litigations depending upon the want of that 'glory'—an heir—is attested frequently by memorable and gratifying solutions.

TREATMENT.

While these tissues in their pathologic state may demand sanatory means and applications as comprehensive as sexual neurasthenia, with its mental hygiene electro-theraputry, baths, massage, counter-irritants, and the like, along with the well-known older remedies, I include as valuable and reliable, for the actions they are sought to produce, the following remedies: Damiana, yerba santa, saw palmetto, liquor sedans, vanilla, black haw, pichi, stylosanthus elatior.

A few cases may illustrate and break the monotony of more general assertion.

Persistent Spermatorrhœa.—Mr. H., of North Carolina, aged thirty, married several years without issue, owing to his persistent spermatorrhœa, which incapacitated the full act of copulation and deteriorated the vitality of the seamen. Upon presentation I found that his urethra along the whole canal was very irritable, particularly so along the prostatic portion; that the organ was continually weeping spermatic and prostatic fluid, and that he suffered ejection during the slightest irritation, mentally and physically, and that he was melancholy and foreboding, and that his skin was cold, clammy and sallow. His general health was very much broken. He had married with the hope of benefitting these unhappy symptoms; but this was a great mistake, one that is made by many laboring under like conditions. Instead of marriage, such parties should seek as a remedy the advice and treatment of the intelligent, scientific physician, one honest and reliable, making these cases a special study. Unfortunately for the community, the advertising quacks have had the majority of these delicate and all-important cases as their greatest source of revenue. Upon passing the sound I found the urethra very tender, with a spasmoid stricture located at or near the prostatic gland. The passage of the sound was continued twice a week to dilate the urethra and to lessen its irritability. During the emission of semen, and just previous to that act, he observed a peculiar sensation or warning similar to the aura of epilepsy. Hence I placed him upon the bromides and atropine at night, and administered the nitroglycerine pills (1-50 gr. each), one three times a day, and or-

dered warm baths and careful diet. The effect of this treatment was to arrest his trouble, and to gradually restore him to physical and mental health. After this treatment had been continued for several months, I placed him upon tonic treatment, consisting of the fluid extract of damiana, belladonna, nux vomica and tincture of cinchona compound, with occasional applications of electricity to the spine. This, together with a select diet, added greatly to his vigor and procreative powers. All unnatural discharges have long since ceased, and his wife, several months advanced in pregnancy.

The number of cases throughout the land is legion, and ever will be until our communities are taught to value scientific and special treatment.

Neurasthenia.—Mr. D., aged twenty-five, a student at law, who also performed the duties of a clerk in an office controlling a large practice. His studies and duties proved too arduous an undertaking, and soon broke him down mentally and physically, being of a nervous and ambitious disposition. He suffered greatly from nervous dyspepsia and general nervous exhaustion. He lost flesh, lost sleep, and was tremulous and depressed, and suffered frequent seminal losses night and day. Upon examining the urethra, it was found to be irritable, with a continuous weeping discharge. No stricture was found. The penis was small, flabby and cold. I ordered him a vacation and administered atropine with bromides until the nervous irritation had subsided. I then gave a tonic consisting of liquor sedans and saw palmetto during the day, with doses of pichi and hyoscyamus at bedtime, as required, making applications of the Faradic current locally and generally every few days. This treatment was kept up during the summer vacation, until late in the autumn, when he returned to his vocation, generally better, and greatly restored in his nervous system. With better sleep, good appetite, and genital functions normal, the use of electricity was continued a term longer when he left my care, with the advice to be more moderate in all things.

Neurosis of Genitalia with Nervous Paralysis.—Mr. K., aged thirty-three, was referred to me because of suffering from general nervous prostration. He is tall, athletic and active; he had lately lost his

color and vivacity; and had acquired an unaccountable dread of persons and places. He was almost a monomaniac in the fear of on-coming "loss of manhood," or paralysis of his procreative powers. Upon examination I found it was his custom to endure prolonged and arduous mental work, neglecting the regularity of sleep, diet and recreation. He had a fine constitution and physical development. His genito-urinary organs were intact and well-developed, and proved readily amenable to treatment by proper hygiene, occasional administrations of electricity, and a tonic consisting of coca, sandal and vanilla. A few months of such treatment fully restored him in every particular. His physician deemed his mental phenomena of an abnormal and perhaps dangerous character, hence he referred him to me. All his unpleasant symptoms passed away as he gradually improved, though a case neglected long enough undoubtedly might have ended in some permanent pathological lesion.

Impotency due to Excessive Use of Tobacco.—Mr. G., aged 31, married, was referred to me as a case of impotency. I found him a hale man, well developed mentally and physically. His muscles were hard and elastic, and he was able to endure great physical strain. All of his organs were well developed—especially those of the genito-urinary system. After a thorough inquiry, I found that he was excessive in the use of tobacco, chewing and smoking to an alarming extent, and at times was in the habit of taking alcoholics too freely, all of which I forbade. I ordered for him a moderate diet and pills of damiana and nux vomica; also the daily application of the Faradic stimulus to the cord and genito-urinary appendages. He was to abstain from all genital exercises. He continued under treatment for several months, with most excellent results.

Tobacco and whiskey are, in my opinion, frequent inhibitors of the sexual act.

CASE 92—Inertia of Uterus.—A young married lady, aged 22, from a fright or shock, suffered abortion during her first pregnancy. After this her menses were scant and irregular, with failing health for several years. She did not become pregnant during this time. After a careful examination, I diagnosed a neurasthenic condition with consequent inertia

of the genito-urinary organs. I ordered generous diet and hygiene, gentle exercise, and administered fluid extracts of Damiana and Haw three or four times daily, commencing with small doses and gradually increasing. After a few months the menses became more regular and pronounced. With general improvement of health and spirits, at the end of the third month of treatment she became enciente, and went through a regular term with a happy delivery.

CASE 163—Impotency.—A gentleman of 36 years, of delicate frame, constantly complained of feeble digestion, irregular bowels and constipation. His complexion is sallow, he sleeps badly, his habits are sedentary, and he is given to literary affairs. Has been married several years without issue. His wife is buxom, active and regular. Upon examination I found his organs rather small, with the power of incomplete erection only. His semen under the glass exhibited but few evidences of life. I ordered a more active life, less study, regular hours and diet. Placed him on fluid extracts of Damiana and Stylosanthus, and after six months careful management he was greatly restored.

In cases of impotence from masturbation, accompanied by spermatorrhœa, we find morbid changes in the vesicular seminales, ejaculatory ducts, bulbous portion of the urethra and prostate gland. Such cases frequently require surgical and special treatment; and in detecting and locating these lesions I have found nothing equal to photographing them by the sound in the galvanic connection, as introduced.

Mixed.

She had read the advertisements

In the papers o'er and o'er,
But had gotten somewhat muddled
As to what each thing was for.

So when she had a bilious turn,

She took some Pyle's Pearline;
She scrubbed the floor with Sozodont,
But could not get it clean.

And for a torpid liver

She took Sapolio,
And put Castoria in the cake;
She got them muddled so.—JAY KAYE.
From *New York Life*, April 20, 1893.

SOCIETY REPORTS.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Meeting October 13, 1893.

DR. T. L. McDERMOTT, President in the Chair.

MALIGNANT DISEASE OF ANTRUM—OPERATION.

DR. W. L. RODMAN: I have a specimen here which does not seem to be a bone but it is, nevertheless, the remains of a malar bone, the seat of malignant disease. It was removed to-day from a patient fifty-two years of age, female, living in Indiana, who came here with a well-marked tumor of the antrum which proved to be a malignant growth. The direction of this tumor was upward and outward instead of internally, the direction in which these tumors usually grow, making the malar bone very prominent. The operation was performed yesterday, and I was assisted by Drs. Dugan and Tuley. I cut immediately down upon the malar bone and this is the remains of it. It does not feel like bone at all, feels more like fibrous tissue. After removing the end of the zygomatic process, which was also diseased, the antrum was exposed and we removed with the curette a large growth sarcomatous in nature, I take it. The antrum was then thoroughly cauterized with zinc chloride. Hemorrhage was quite profuse but easily controlled by tamponing with gauze. The patient stood the operation very well; I believe when she went on the table the pulse was 116 and at the close of the operation the pulse was 120. What is a little remarkable is the fact that this evening her pulse is only 68 and good volume.

I was then led to do this operation rather than the more standard one of excision of the upper jaw, on account of the fact that I think recent investigations have shown rather clearly that the old operation of excision of the superior maxillary bone is perhaps not a justifiable operation. Butlin, in reviewing 108 operations removing the upper jaw, states that the immediate mortality is rather more than 30 per cent., that of this 108 cases only five passed the three year limit which can be looked upon as a cure. There is very little, I think, to promise patients after excision of the upper jaw, because nearly all of them return very speedily, and, in view of the great mortality, other operations should be done if possible. The tumors affecting the upper jaw are in a very large percentage of cases malignant. In a paper read two years ago before the State (Kentucky) Society held at Louisville, I went over the subject pretty

carefully and found that 76.3-10 per cent, are malignant, the larger proportion of them being sarcomatous rather than carcinomatous, and 23.7-10 per cent. benign. Of these rather more than 8 per cent. are cystic, the balance fibromas, osteomas and enchondromas.

In the case reported by me to-night, the tumor has not been subjected to a microscopical examination, but from its macroscopic appearance there is very little doubt in my own mind as to its being sarcomatous in nature.

DISCUSSION.

DR. S. G. DABNEY: I would like to ask whether in early stages of these growths within the antrum, the so-called Hering test is used for illumination within the mouth. My own experience with it in diagnostinating suppuration of the antrum has been favorable. I believe if we will observe just beneath the eye, we will find in diseases of the antrum the affected side is rather darker than the other, even when there is no difference in transparency lower down in the cheek. My recollection is that this test was first used for differentiation of tumors of the antrum, to detect the solid from cystic tumors. Is its use satisfactory in making the diagnosis of tumors in the antrum?

DR. D. T. SMITH: I would like to ask the justification of any operation at all in this situation. A suppurative condition I judge could be ascertained and differentiated from others, which would naturally require operation or opening at all events. On the other hand, if operation is demanded, I should think complete excision of the jaw rather than partial excision would be preferable and promise more for the patient in the way of permanent results.

DR. W. L. RODMAN: Answering Dr. Dabney's question I have never seen the test used; it seems to me it would be a valuable means of diagnosis. It would possibly enable us to make a more accurate diagnosis in these cases, because it would show if the tumor had encroached upon the nares, as these growths usually do.

The objection to complete excision of the upper jaw is that the primary mortality is more than 30 per cent., and if you cannot promise very decided benefits from an operation that gives so high a mortality, then it occurs to me that the operation is not justifiable. I was led to give this woman the bene-

fit of surgery particularly on the account of the fact that she was suffering great pain from pressure. I believe by the removal of the diseased bone and the thorough curettment of the antrum, the patient's life will be prolonged, and the mortality of an operation such as was done in this case I do not think is at all considerable.

DR. W. C. DUGAN (Visiting): There is another feature in this case that struck me as being very peculiar, and that is there was no encroachment upon the nares. The patient was able to breathe through the affected side without trouble, and in discussing the case at the last meeting of the Surgical Society, where the patient was shown, this fact was mentioned. It struck me then that if there ever was a favorable case for operation this was one. We were very much surprised at the operation to-day to find that the growth had extended from the malar bone to the upper portion of the antrum, rather than from the antrum outwardly. I agree with Dr. Rodman that the patient was relieved of a great deal of pain. She was unable to open her mouth before the operation, and I am quite sure she will be able to do so now, for in my opinion the pain was largely due to the tumor being beneath the masseter muscle.

DR. W. L. RODMAN: In reporting the case I neglected to mention the fact that this patient was unable to open her mouth before the operation, but as the masseter muscle was cut I am certain she will be able to do so now and masticate her food.

DR. W. C. DUGAN: I am very much surprised at the high mortality of this operation. I have had several similar operations lately without any immediate fatality, but I am like Dr. Smith—it is rather doubtful in my own mind as to whether this operation should not have been total excisions as I feel confident that we could have gotten all the growth out.

DR. W. L. RODMAN: The literature of the subject is rather conflicting: Gross states that he operated upon twelve of these cases, excising the jaw as many times, without a single death, and makes the most extraordinary statement that the operation is free from danger. Yet Butlin, in a very careful review of 108 cases, states that the primary mortality is more than thirty per cent., and only five of them lived past the three years limit, which is ordinarily regarded as the proper time to suppose that a cure has been effected. I would pay a great deal more attention to Butlin's statistics than those compiled by anybody else, as we know that his life work has been devoted to malignant disease, and he has shown most extraordinary energy in following up his cases.

DISCUSSION

of Dr. S. G. Dabney's paper. See page 88.

DR. J. M. RAY: One point that impressed me concerning the obstruction of the canal from wax, is the habit some people have of having recurrent attacks of accumulations of wax in the ear. I have in mind a man from whose external auditory canal I have removed twice a year for the last four years enormous accumulations of wax. His hearing powers are perfectly normal, and careful examination reveals no disease of the middle ear. Again, its proneness to occur in warm weather.

With reference to inflammation of the external auditory canal: The majority, I see, involve the outer part of the canal and are furuncular. I have seen several cases where incisions have given relief, and a few in which they seemed to give no relief whatever. I think Roosa teaches that incisions as a rule give very little relief to inflammations of the external auditory canal. One of the best means I have found to give relief is to allow the patient to lie down and pour hot water into the external canal, keeping it filled with hot water. I do not remember to have seen a case involving the mastoid periosteum as a result of external ear inflammation. There is no doubt but in furuncular inflammations of the canal, there is some general systemic condition that underlies it.

I have had under observation during the present summer a young man who has had a most obstinate attack of recurring furuncular inflammation of the external auditory canal. I saw him in four or five attacks; he suffered great pain, and at last I advised him to take a vacation and go to the country. He went up in Illinois somewhere, remaining two or three weeks, and has not had any inflammation of the canal since his return. While he was under my treatment I gave him tonics—Fowler's Solution, etc.—which seemed to have no effect. His trip to the country, getting fresh air and country food, seemed to produce a change in his condition for the better, and since his return to the city has had no recurrence of ear trouble.

DR. T. L. McDERMOTT: In the last week I remember reading a pamphlet setting forth the fact that poultices applied externally had very little effect upon internal inflammations of the ear. In this article the author advocated the pouring of hot water current into the ear, which would in the majority of cases afford relief. It struck me as a very wise procedure, and Dr. Ray's remarks recall it.

I have under observation now a little boy, three or four years of age, who has fever, and apparently at first suffered from some bowel trouble; pain quite severe, but could not be definitely located, owing to his age. On the second night he complained of severe pain in the ear, lasting through the night. His head was kept in one position, and this symptom was so persistent as to suggest

torticollis. This morning he still complained of pain located in the ear. Temperature yesterday 103° F., this morning $102\frac{1}{2}^{\circ}$ F. He has had a typical clonic spasm from the history elicited from the family. I believe that this child has some trouble in the middle ear not yet fully developed, which is causing the elevation of temperature. Since I have seen the case there has been no contraction of the muscles which we would expect to find in torticollis, and no tenderness anywhere. There is no contraction or dilatation of the pupils, no cough, no sore throat, no diarrhoea, and nothing indicating disease, except this obscure ear trouble.

DR. J. A. LARRABEE: I believe that the child is suffering from rheumatism, a disease frequently overlooked in childhood.

DR. J. M. RAY: There may be some middle ear trouble, but mastoid tenderness may occur from the drawing effect upon the sterno-cleido-mastoid muscle.

DR. T. L. McDERMOTT: It is one of three things, external ear trouble, rheumatism or developing cerebro-spinal meningitis, the symptoms are not localized.

DR. S. G. DABNEY: The discussion has taken rather wider turn than the character of the paper called for. There is no doubt that hot water allowed to run for a long time is one of the best methods of treating inflammations of the external auditory canal, because the hot water reaches the drum membrane whereas poultices must be an inch more or less removed from it. I believe that the Fountain syringe is the most valuable for this purpose. Parents and nurses are very apt to use the Piston syringe, which is too forcible and adds to the irritation already existing.

As regards complication of the mastoid in inflammation of the canal: I have encountered this in two or three cases in children, but the inflammation was always confined to the periosteum over the mastoid process and did not involve the cells of the bone.

TWO CASES OF FOREIGN BODY IN THE EAR.

DR. J. M. RAY: I will report two cases bearing somewhat upon the paper read by Dr. Dabney—cases of foreign body in the external ear. I recently had under observation two cases in which insects had gotten into the antrum ear and remaining there for some time. One case is now under observation: The patient is a young lady who while riding on a street car at night suddenly felt something enter her ear. She went home and poured something in her ear that she thought would kill the insect and the next day consulted a physician, who said there was nothing in the ear. For six weeks she had no trouble then she began to have violent ear-ache. She suffered several nights before

consulting me. Upon examination I found the canal blocked by something, I was unable to make out the nature of, she did not at first give me the history of the insect. She said it had been so long she had about forgotten the occurrence. I then began to syringe the ear and removed several pieces of black material, and upon further syringing and with a dull curette I picked out a headless insect as large as a bean; after I had syringed this all out, and examined again I could still see something lying at the bottom of the canal close to the drum membrane. The canal was so tender and inflamed that I could do nothing further toward removal, so advised the use of hot water injections. The ear suppurated in a day or two, and she went through a case of suppuration of the middle ear. After that subsided I could still see something in the canal, and with a strong solution of cocaine allowing the patient to lie on her side for some time until anaesthesia was produced I passed a dull curette behind the body and picked out the head of the insect as large as a shot and very hard, which had remained there through the suppuration and for six weeks previously.

No. 2.—The other case, a gentleman stepping off the street car one night felt something fly into his ear, and suddenly became so dizzy that he could with difficulty walk. He went home and poured oil in his ear to kill the insect. He remained very dizzy during the next day. The second day he consulted me and upon examination I discovered an insect lying in the canal. It was removed by syringing, when the patient again became very dizzy and had to lie down for a few minutes. The insect had dropped down against the drum membrane. The peculiar feature in the case is the intense dizziness caused.

OPHTHALMIA NEONATORUM.

DR. T. L. McDERMOTT: A lady called at my office with a little child evidently suffering from ophthalmia neonatorum. As the case was not in my line I advised that she consult an oculist. She said another physician attended her during delivery and had been treating the child's eyes since. Of course what the nature of his treatment was, or how often he visited the child, I do not know. I sent her to Dr. Ray, and I want to ask the doctor one question in regard to the subject; whether under proper treatment immediately after birth the trouble in the majority of these cases could not be averted.

DISCUSSION.

DR. M. RAY: The case referred to by Dr. McDermott belongs to an unfortunate class, the cornea are perforated, one eye collapsed; the other seriously affected, but may retain a little sight. Ordinarily cases of ophthalmia neonatorum come on about four days after

birth and run a very rapid and often destructive course. I do not know that I can say very much about the case in question. The visiting physician evidently did not impress upon the mother the importance of the trouble, as she had not kept the eye free from pus.

At the meeting of the American Ophthalmological Society the past summer quite an extensive discussion was carried on with reference to the responsibility of the doctor in cases of ophthalmia neonatorum, and it was the concensus of opinion that cases were sometimes lost, and it did not make any difference who treated them or the method of treatment. The doctor should not be held accountable for an eye destroyed in ophthalmia neonatorum. There is one class of cases that I believe almost invariably go on to destruction, and that is in a premature child. I never saw a case of ophthalmia neonatorum in a child of seven or eight months but the eyes were seriously injured. I had a case of this nature during the summer. I saw the child three or four days after the eyes became involved and at that time one cornea had become infiltrated; the other eye quickly became involved, and in a short time was also destroyed. The case referred to by Dr. McDermott was a seven-months child.

I believe that such children are peculiarly prone to this affection and suffer more severely from the effects than those born at full term. It is probably due to the fact that the resisting powers are greater in a child fully matured than one prematurely born.

DR. F. WILSON: What is the most successful plan of treatment?

DR. J. M. RAY: Perfect cleanliness is the best treatment I know of. I think the best local application is nitrate of silver; this to be used by some one who knows exactly how to do it. If due care is exercised I believe that a ten to twenty or even forty grains to the ounce solution of nitrate of silver can be employed with benefit. I remember a case I had several years ago in which I used a forty grain solution of nitrate of silver, stopping a purulent ophthalmia in one eye of a child, the other eye being seriously affected at the time. By thoroughly cleansing the conjunctiva and applying nitrate of silver it ran a very mild course and in less than a week the eye had perfectly recovered. The other eye in which the trouble had existed for a greater length of time, was two or three weeks recovering and with a superficial corneal abrasion. I believe the time is not far distant when all obstetricians will recognize the importance of preventive measures in these cases. I am sure such methods as those of Crede will prevent many cases. The Louisville City Hospital has during my ser-

vice always been unfortunate in having a number of such cases.

DR. J. A. LARRABEE: In treating ophthalmia neonatorum I do not think it is safe to intrust the cleansing of the eye to anyone except the physician himself. I have had some nurses of large experience, and even then it is very risky the first twenty-four hours of the treatment to intrust them with the cleansing of the eye, giving the most minute directions. It is a very difficult thing to do I find. The eye shuts up like a mollusc and the more pus there is the tighter it is closed. It will hold a teaspoonful of pus. The lids come out to a level with the supercillary ridge remaining there swollen. I have had a nurse tell me there was nothing in the eye, when upon a careful personal examination a large quantity of pus has been found. Therefore, as has already been stated, I do not think it is safe for any physician to intrust this work to nurses, even trained nurses. I have used nitrate of silver by preference, getting it in just as soon as I could. I have more confidence in it than in any other agent outside of cleanliness.

DR. D. T. SMITH: If there is one thing that has puzzled me more than anything else in medicine, it has been to make up my mind as to the proper treatment for ophthalmia neonatorum, from reading books. They generally recommend nitrate of silver, but scarcely two of them agree as to the strength that should be used. Some insist that it should be very weak, others insist that very strong solutions are desirable. I am very doubtful in the average case whether nitrate of silver is required at all. I believe that Dr. Ray has solved the whole problem in saying that absolute cleanliness is the best treatment. The child's lid should be thoroughly cleaned every half hour with water about as salt as the normal tears, or at least every hour, all the pus being removed by gently pressing the under lid, and the lids never be permitted to stick together. I positively enjoin that somebody be up with the child night and day. Probably the most of us have suffered from ophthalmia at times, and know how painful a small particle of pus is under the lid. By gently pressing the lid and passing the finger over it this can almost always be removed. I have had such satisfactory results in the treatment of this affection simply using salt water, keeping the eyes perfectly clean, that I feel like using nothing else. I have employed nitrate of silver in some cases trying to follow the teaching of the latest books, then I would read the work of another author advocating a different strength of the solution, until I have found there is such a great variation that I have about come to the conclusion that any treatment which admits of such variation would

admit of being dispensed with altogether. As a rule I do not believe we visit these patients with sufficient frequency, leaving the treatment too much in the hands of the attendants. We should see them often, and insist that some one be present at all times to keep the eyes clean and taking pains to see that our instructions are understood.

DR. J. W. IRWIN: My views are a good deal in accord with Dr. Smith's in regard to the treatment of ophthalmia neonatorum. I have seen a number of cases of this disease, which come on one, two, three or four days after birth, and I have never seen a child to lose an eye or have a perforation of the cornea. Furthermore, in no instance have I had to apply nitrate of silver solution in the treatment of these afflictions. Had they been of gonorrhœal origin, it is possible I would not have gotten off so well. Therefore I am inclined to the opinion, so far as my experience goes, that this disease even in the majority of cases, is not of gonorrhœal origin. The treatment in the cases I have seen was simple. I have had the eyes washed out clean with a weak solution of borax and water, and subsequently with one-fourth grain of sulphate of zinc to the ounce of water instilled into the eye with a dropper glass six or eight times a day. In a few instances, where the suppuration was very profuse and where it was very hard to control, I had the nurse to apply a solution of bichloride of mercury, one grain to one ounce of water, with a camel's-hair pencil once a day only. Two or three applications of this solution sufficed to put an end to the disease. This I believe to be the best means of all for controlling these disorders. When I was a student I was taught that sixty grains to the ounce nitrate of silver solution would be required in these cases. I have read in books that it takes anywhere from five to fifty grains to make a solution sufficiently strong to be effective. I have never yet had to apply to the eyes of a young child nitrate of silver in any form.

DR. S. G. DABNEY: I would like to say something in regard to both cases reported by Dr. Ray, as they are both of extreme interest. Concerning foreign bodies in the ear: I wanted to include something about this in my paper, but did not do so. A mistake that is very often made in removing foreign bodies from the ear, is to use instruments. Sir William Dalby goes so far as to say that injury is far more often done to the ear by attempted removal of foreign bodies than by the foreign body itself. In almost every case the syringe alone is sufficient for the removal of foreign bodies from the ear; and forceps, spoon, or other instrument, are both needless, and, except in expert hands, dangerous. In one class of cases the syringe

should not be used, namely, when the substance is one that swells when in contact with water—peas, beans, etc. I remember one case where a child was brought to me who had gotten a bean in the ear; it had been syringed several times, but the bean had slipped deep in the canal and was swollen from the use of water in attempts to remove it, and the canal itself was already inflamed and narrowed. In that case it was necessary to give chloroform before the bean could be gotten out. It was easily removed, and in a day or two the swelling passed away. Cases of this kind, however, are very exceptional. Another case was a child who had gotten a grain of corn in the ear; the family physician had made several attempts to remove it by injections of water, but had not succeeded. The grain had been in the canal for some time, and the water had caused it to swell, so that it could not be removed except by taking it out in pieces. This is nearly always the case where the grain is not removed by the first injection of water.

As regards live insects in the ear: Patients very often go to their doctor and say they have a little bug in their ear as they can hear it. I remember one case where a small insect had gotten in the ear of a patient, and was still alive when I saw it many hours afterward, and was fluttering, but usually the insect soon dies after it gets in the ear.

I was particularly interested in the discussion of ophthalmia neonatorum. Just before the society was called to order I mentioned a case to Dr. Tuley which I saw for the first time to-day and found with a deep ulceration of the cornea. The child is now about two weeks old; the accoucheur dismissed both the mother and child six days ago, and I suppose the child was then doing well and the eyes improving. Since that time, however, the ophthalmia has not improved and now the condition of one eye is critical.

As regards the treatment of ophthalmia neonatorum—there can be no question but absolute cleanliness is the key-note to the whole situation. This carried out with care is usually alone sufficient for a cure but to hasten the cure there is nothing equal to nitrate of silver solution, and I am a little surprised that Dr. Smith should have found such diversity of opinion among writers as to the strength to be used. For ordinary purposes a two per cent. solution, ten grains to the ounce should be applied. In a report from the Presbyterian Eye and Ear Hospital of Baltimore sent out last June, Chisolm says the old plan of treatment in this disease still holds good; that is a four per cent. solution of boric acid used by the nurse for cleansing the eye as often as matter accumulates and the daily application of nitrate of silver by

the physician, usually ten grains to the ounce. This is the course of treatment I usually follow.

I was particularly interested in the point made by Dr. Ray in regard to suppuration of the cornea being so much more frequent in children who were born prematurely. This is in accord with the well known fact that disease of the cornea is most severe in debilitated subjects, even in adults, the corneal condition is often an index to the general health.

DR. H. A. COTTELL: The subjects under discussion are exceedingly interesting, not only to the specialist, but to the general practitioner. Concerning the matter of foreign bodies in the ear: I believe every general practitioner should keep an ear speculum and mirror and know enough about the anatomy of the ear to make an intelligent examination, not simply turn the patient around to the window as so many of them do and look into the ear without speculum or glass. He does not see to the bottom of the canal by that means, and many patients are allowed to go away with foreign bodies in the ear. I keep a set of ear specula and many times I have removed foreign bodies from the ear. I had the honor of removing an insect from the ear of a distinguished surgeon the other day. He came into my office stating that he "knew he had a bug in his ear, that he could hear it buzz," asking me to get it out. I took the speculum and glass, secured an illumination and detected a little brown object in the canal which proved to be a very small insect, (of the beetle order, I judge) and alive. It was very easily removed with a syringe and some water.

I have seen accumulations of wax in the ear, as you all have, which practically amounts to the same thing as a foreign body, and sometimes sets up a considerable trouble of a reflex character. But I want to have the subject of reflexes due to irritation of the external ear brought up some time for discussion.

A word or two in regard to ophthalmia neonatorum: Of course all doctors see this disease, and although I have never had a severe case to develop in my practice, I have had one or two pretty severe ones brought to me. One I remember came from another city; the eyes looked to me as if they would be destroyed. I did not have the temerity to attempt to treat the case. I sent the case to the Infirmary and asked Dr. Cheatham to see it. I remember he put the child in charge of a trained nurse and was very specific in his directions to have the eyes cleansed with considerable frequency, and that he used a solution of nitrate of silver of different degrees of strength, beginning with a weaker and going up to a stronger

solution. In a few days the child was well. That child would certainly have lost its eyes if it had gone on under the treatment the country doctor was giving it.

Concerning the question of using peroxide of hydrogen in the treatment of purulent conjunctivitis: Peroxide of hydrogen ought to be the ideal remedy for that trouble, and I think the reason it is not used is that it is too irritating, owing to the acid it contains. Now there is no peroxide of hydrogen made that does not contain acid. When the Oakland Company's came out some time ago, it was received with a great deal of enthusiasm because it was only slightly acid. I took a sample bottle of the Oakland Company's and made some experiments with it, and while it was very much less acidulous than the other preparations, it still contains quite an excess of acid and is bound to be irritating. If used in the eye it would have to be diluted to such a degree that it would not have any marked effect. If chemists can make a peroxide of hydrogen which shall be neutral, they will put in our hands a very valuable agent.

DR. H. E. TULEY (visiting): During my term of service at the Sloane Maternity Hospital in New York there were 202 births; the Credé method was observed in every case, two drops of two per cent. solution of nitrate of silver being instilled into each eye immediately after birth, and there was not a single case of ophthalmia neonatorum during that time. This method is followed in every case, after birth, and I do not think they have had a case of ophthalmia neonatorum there in a long time—I know they have had none in the last thousand births.

DR. P. F. BARBOUR (visiting): While I was in the City Hospital here, we adopted a method of preventing ophthalmia neonatorum which succeeded in every case. This method was to cleanse thoroughly the child's hands with boric acid solution. It seems to me that they should receive attention. One of the first actions on the part of a child is to rub its hands into the eyes. I believe if the hands as well as the eyes are kept cleansed with some mild antiseptic, there will be much less of this trouble.

DR. T. L. McDERMONT: In all the women we deliver in the course of many years, it is possible that we might not have a case of ophthalmia neonatorum, then again it might occur very frequently. Of course there are reasons why there should be more cases in hospital practice owing to the class of patients presenting at such an institution for delivery. Gonorrhœal infection is much more liable to be encountered there than in private practice. Our discussions of matters of this kind will bring them to the attention of other and younger physicians and I believe good will

result from greater care exercised in an endeavor by proper treatment to prevent trouble in this direction.

DISCUSSION

of DR. T.H. Stucky's paper. See page (91).

DR. T. L. McDERMOTT: I had an experience of similar character at the Springs this summer: A man was suffering from alcoholism and I prescribed paraldehyde in small doses. The effect was so pleasing that he consumed the whole vial, six ounces, in one day without any perceptibly bad effect. In another case at Seelbach's Hotel, in ordinary doses, it produced violent heart symptoms with evidence of poisoning. Here are two cases in which the action of this drug was directly opposite. I remember prescribing paraldehyde to another patient who was suffering from alcoholism. The druggist two weeks afterward called my attention to the fact that this man was getting from four to six ounces of paraldehyde per day, and asked if it was my wish to have it continued. I of course instructed that he be sold no more, as I did not intend for it to be continued. That case was similar to the one reported by Dr. Stucky—the man was going about the Springs taking four to six ounces of paraldehyde a day instead of whisky.

DR. J. W. IRWIN: What were the character of the heart symptoms?

DR. T. L. McDERMOTT: Palpitation; respiration was also depressed. I understand that this patient died three or four months afterward in New Orleans, but I did not ascertain the cause of death.

DR. J. W. IRWIN: I was greatly interested in Dr. Stucky's report; it comes right within the sphere of my own observations perhaps more than any other. I have had some experience in treating persons suffering from insomnia in its various forms, and have prescribed paraldehyde a number of times. I recall one case where a patient had been taking paraldehyde for nine months every night. The dose has not been increased—one-half to one ounce every night. When he first began the use of paraldehyde it had a stimulating effect, as though he had been taking alcohol; but this effect did not last long. He then began to suffer from suffusion of the eyes with redness of the conjunctiva and dilatation of the pupils, which would last for one or two hours after getting up in the morning. Soon after going out into the open air the pupils become normal but the suffusion of the eyes continue. He suffers from a little redness or flushing of the face; at times he shows evidence of uncertainty of gait, and in walking across the floor he staggers. He does not plant his feet on the floor as a healthy man should ordinarily do. There is no other change in his condition; it

has not affected the heart, nor does it today.

No. 2.—Another gentlemen came under my observation who had spent a year or two abroad and had been taking paraldehyde for insomnia. He used Flexner's preparation in doses of half ounce at night causing sleep of six to eight hours. At the time I saw him he was suffering from a feeling of constriction about the stomach, as though a band had been tied around him. He had not been using alcohol or anything that would have put the stomach out of order and he thought the paraldehyde might have been the cause of his trouble. I had the paraldehyde stopped had the urine examined and found a trace of albumen with hyaline casts, slightly granulated. This was the report of the chemist. After two weeks without paraldehyde, the constriction had passed away, the trace of albumen had disappeared, and so did the casts in the urine. He sleeps now without paraldehyde, takes no medicine of any kind and I believe in this case it was only imagination that he could not sleep.

I have several other cases who are using paraldehyde but these are the most striking. The largest dose I have to prescribe in any case was one ounce of Flexner's Elixir. One gentleman is taking pure paraldehyde and he thinks it is the greatest remedy in the world for insomnia. The only bad effects I have observed after the use of paraldehyde are that in one case it produced suffusion of the conjunctiva, flushing of the face in the morning, dilatation of the pupils and a slight conjunctivitis. In a few instances in acute disease I have prescribed paraldehyde in large doses to cause sleep; I have given as much as six ounces in one night to one patient. This caused an acceleration of the pulse from ninety or one hundred to one hundred and twenty and the patient awaking from sleep rather weak and feverish. These are about the only untoward symptoms I have observed so far.

THE MARK OF THE BEAST.—Forester—“Did you see me making a fuss over that ‘sby?”

Lancaster—“Yes. How much do you owe him?”—*Truth.*

CAUSE FOR THANKS.—Teacher—Johnny, can you tell me anything you have to be thankful for in the past year?”

Johnny (without hesitation)—“Yes sir.”

Teacher—“Well, Johnny, what is it?”

Johnny—“Why, when you broke your arm you couldn't lick us for two months.”—*Life.*

THE LIBRARY TABLE.

BOOK REVIEWS.

A Practical Treatise on Materia Medica and Therapeutics. By Robert Bartholow, M. A., M. D. LL.D. Eighth Edition, Revised and Enlarged. New York: D. Appleton & Co., 1893.

The decennial revision of the United States Pharmacopœia involves so many changes in remedies and formulae that a treatise on Materia Medica must, of necessity, be newly edited to make it conform to the only official standard. Formulae have been changed as required by the Pharmacopœia, and a list of remedies, many of which have only recently appeared, have been added. An account, more or less complete, of the various new synthetical products will be here found. So important are their attributes, so largely have they come into use, and so great is the demand for true information regarding them, that a text-book would be considered wanting in thoroughness and completeness if it contained no reference to the more important of them.

We know of no work on Materia Medica and Therapeutics that we could more unhesitatingly recommend than this one, and we express the belief that this new edition will prove still more worthy of the remarkable favor which the work has enjoyed from its first appearance.

An Outline of the Embryology of the Eye. With illustrations from original Pen-Drawings by the Author. By Ward A. Holden, A. M., M. D., New York. G. P. Putnam's Sons.

The research was carried out in the New York Ophthalmic and Aural Institute, and is based upon the examination of a great number of specimens. The chick-embryos were obtained by incubation, were hardened in Kleinenberg's or Muller's fluid, and stained with carmine and haematoxylin-eosin. The pig-embryos were obtained fresh and hardened in Muller's fluid after decalcifying, when necessary, with phloroglucin or hydrochloric acid mixtures, and the sections were stained mostly with haematoxylin-eosin. The study received The Cartwright Prize Essay for 1893.

The author presents a clear and comprehensive description of the development of the eye giving first a brief and purely schematic sketch of the processes which take place, explaining them with diagrams. He next gives an accurate histological description of the various parts of the eye in their successive phases of development, and illustrates these descriptions with careful drawings from actual preparations.

The Child, Physically and Mentally—Advice of a Mother, According to the Teaching and Experience of Hygiene Science. Guide for Mothers and Educators. By Bertha Meyer. Translated by Friederike Salomon Revised by A. R. Aldrich, New York; M. L. Holbrook Co.

Thirteen years have elapsed since Bertha Meyer's book "From the Cradle to the

School" was translated and offered to the English speaking public. "The Child" which we now have before us, shows the same careful hand, the same endeavor to comfort, and to educate; and if the precepts here laid down be observed, blessing and health to children are bound to follow.

Many helpful suggestions are made. Throughout the entire book great stress is laid upon hygienic rules for attaining physical and mental health and educating body and mind harmoniously.

The 155 pages are deserving of a careful study.

Surgery. By Bern B. Gallaudet, M. D., Demonstrator of Anatomy and Clinical Lecturer on Surgery, College of Physicians and Surgeons, New York, Visiting Surgeon, Bellevue Hospital, New York, and Charles N. Dixon-Jones, M. D., Assistant Surgeon, Out-Patient Department Presbyterian Hospital, New York. Being the final volume of "The Students Quiz Series." Edited by Bern B. Gallaudet, M. D. Duodecimo, 291 pages, 149 illustrations. Cloth, \$1.75. Philadelphia: Lea Brothers & Co., 1893.

The author has endeavored to present this book, not as a compend or digest of surgery, but rather as one which would *explain*. Among the principles of surgery, Inflammation is one, the clear comprehension of which seems attended with peculiar difficulties. This book elucidates this subject fully. But as it is a fact that the *varieties* of inflammation *themselves* are recognized as being either "specific" or "non-specific," and that putrefaction is a process distinct from inflammation, the author deemed it best to avoid all discussion, and to classify the bacteria as *causes* in the same way in which their effects—i. e., inflammation and putrefaction—are classified.

In addition to inflammation, three other subjects have received especial attention. These subjects are: Tumors and Cysts, Brain Surgery, and Abdominal Surgery.

Essentials of Minor Surgery, Bandaging, and Venereal Diseases. Arranged in the form of Questions and Answers. Prepared especially for Students of Medicine. By Edward Martin, A. M., M. D. Second Edition, Revised and Enlarged. 78 Illustrations. Philadelphia: W. B. Saunders, 1893.

This little volume, being N^o. 12 of Saunders's Question-Compends, has been thoroughly revised and brought up to the present standard of surgical practice. A large number of illustrations have been redrawn and engraved. Many of the omissions made in the first volume have received careful attention in this edition.

New Truths in Ophthalmology as developed by G. C. Savage, M. D. Thirty-two Illustrations. Publishing House of the M. E. Church South, Nashville, Tenn. 1893.

The author states that "In presenting this little volume to ophthalmologists who read," he "feels that he is doing them a service that will be appreciated." The book is considered under three parts:

Part I. New Truths in Ophthalmology.
 Part II. Contributions to Old Studies.
 Part III. Operations.

For all that is new or of any value in this little volume, the author might have satisfied his literary ambitions with a few contributions to some of our medical journals.

Essentials of Bacteriology. Being a Concise and Systematic Introduction to the study of Micro-organisms. For the use of Students and Practitioners. By M. V. Ball, M. D. With eighty-one illustrations, some in colors and Fine Plates. Philadelphia: W. B. Saunders, 1893.

In this little book of some 200 pages, Bacteriology is considered under two heads, General Considerations and Technique, and special Bacteriology, together with an elaborate appendix.

That this value should so soon reached its second edition, confirms our views of its success already expressed in the review of the first edition.

The Physician's Visiting List for 1894. Forty-third year of its publication. Philadelphia: P. Blakiston, Son & Co.

What better evidence of success is wanting than the fact that this Visiting List has reached its forty-third year?

It contains sections on New Remedies, Incompatibilities, Poisons and Antidotes, Disinfectants, Examinations of Urine, Differential Diagnosis and Treatment of the Simpler Diseases of the Eye, Table of Eruptive Fevers, Asphyxia and Apnoea, a New Complete Table for Calculating the Period of Utero-Gestation, etc. Aside from these features, its size and weight recommend it. It is claimed to be the smallest and lightest Visiting List, published. A very great advantage, when one considers the number of articles the physician has to carry in his pockets. THE MEDICAL AND SURGICAL REPORTER has decided not to publish a Visiting List this year, but has adopted and offers for sale this one to its subscribers.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE UNIVERSITY MEDICAL MAGAZINE
 for January. Dr. James Tyson contributes a clinical lecture on

Croupous Pneumonia.

The author states that he has no doubt as to the propriety of bleeding in certain cases of pneumonia and the propertime to bleed is at the commencement of the disease. He thinks it is the frequent breathing next to the character of the pulse, or sometimes even the first, which should determine the taking of blood; and he would prefer even to run a little risk, if the pulse rather contra-indicated it, should the patient breathe as rapidly as in one of the cases described—72 times a minute. No symptom, as a rule is more promptly relieved by a bleeding in pneumonia than pain. He thinks fewer cases can be hurt by bleeding than we are led to suppose, that we bleed too little in this disease and if we bled more frequently more cases would get well.

Dr. M. Howard Fussell describes a case of

Tetany.

The case is remarkable in showing in the same individual a typical case of tetany and of epilepsy. The epileptic seizures were usually preceded by an attack of tetany, though the first and last convulsions occurred when the child was free from tetany. It would seem as if the two diseases, certainly in this patient, were simply variations of the same condition. Laryngismus stridulus was a prominent symptom in the attacks of tetany. The child was not rachitic. The tetany oc-

curred in the spring and fall and disappeared in the summer and winter. The causation of an attack in this case appeared frequently to be disturbances of digestion. He concludes that tetany and laryngismus stridulus are identical conditions and not distinct diseases.

Dr. William Osler reports a case of "Parotitis in Pneumonia," which is interesting on account of the rarity of the complication. The patient died.

The same author also reports a "Case of Pericarditis Treated by Incision and Drainage." The points of interest about this case are: (1) A septic pericarditis following acute necrosis of the bones of the nose; (2) the peculiar delirium occasionally seen with pericardial effusion; (3) the onset, two weeks after operation, when the patient had been doing well, of excessive cardiac debility, probably due to myocarditis. The patient died. No autopsy was obtainable.

Dr. James Wallace contributes a scholarly paper on "Gonorrhœal Ophthalmia." Dr. Albert S. Ashmead in a short paper on "A Source of Infection on American Prairies" denies that typhoid fever can arise *de novo* and is inclined to attribute outbreaks of the disease among emigrants to infection of the streams by previous emigrant trains.

The remaining paper is by Dr. William Goodell on "The Great Medical Error of the Day." In it the author states that too much stress is laid upon lesions of the reproductive organs in the treatment of the diseases of women and too little heed is paid to the nervous system. The author cites cases to prove the position taken in the paper.

THE BRITISH JOURNAL OF DERMATOLOGY
for December. Sir Dyce Duckworth, M. D.,
describes

**A Case of Linear Atrophy of the Skin, with
Hyperesthesia of Adjacent Parts.**

Three months after an attack of typhoid fever the patient, a well-nourished lad of fifteen, noticed marks on his left thigh at the outer aspect, and similar ones above each ankle on the outer side of the lower legs. About the same time he experienced undue sensitiveness in the neighborhood of these marks, and also over adjacent parts, as on the outer aspect of the thigh. Examination showed several stripes of linear atrophy running across the outer part of the left thigh and on the outer side of both lower limbs above the malleolus. The knee-jerks were natural. The prognosis in any such case is good, but it is not to be expected that the integuments will ever again become natural. The therapeutical indications are to restore the general level of nutrition by good diet, and to employ such remedies as arsenic, iron, and cod liver oil. Warm sea-water baths, or peat baths, may be recommended, and feeble galvanic currents applied for short periods to relieve the hyperesthesia. The appearance presented by the atrophic stripes is exactly that seen after prolonged distension of the integuments from obesity, lipomata, pregnancy, or chronic dropsey from cardiac or renal disease.

But in these cases the condition arises without any recognizable distension, and is probably due to neuritis involving both sensory fibres and those regulating the nutrition of the affected area.

Dr. G. Stopford Taylor and Frank H. Barendt report

Three Cases of Adenoma Sebaceum in One Family.

The author believes that the name Adenoma Sebaceum is well chosen; for it is a benign growth beginning in a gland, and the adjunct sebaceum marks its nature, both of which points the microscopical evidence completely confirms. The fact that some psychic disturbance is almost invariably present is of use in arriving at a diagnosis. The treatment is unsatisfactory, although surgical measures have improved the disfigurement in certain cases, especially where the papules are few in number. The author believe that the disease is of the nature of a congenital overgrowth of the sebaceous glands.

Dr. S. Pollitzer reports

A Case of Xanthoma Tuberosum Multiplex.

The noteworthy points in this case are a slight tendency to grouping in geometric figures (the parallel streaks on the left arm and the ring on the right palm) and the reddish hue apparent in some of the patches. This latter fact appears to the author of especial importance in view of the relations between this form of Xanthoma and the disease as it occur in glycosuria. In a large number of cases of Xanthoma there is a distinct history of hepatic disturbance, especially of jaundice.

In this case there was also probably some liver trouble, if we may interpret the attacks of severe epigastric pain referred to as due to biliary colic.

The same author also reports a "A Case of Xanthoma Diabeticorum."

Alfred G. Francis, M. B., reports "A Case of Lymphangioma Circumscripum Cutis."

THE JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES

for January. Dr. Albert S. Ashmead presents

Extracts from a Japanese Work on Syphilis.

published in Kioto in 1801. According to the author, syphilis existed and was included among skin diseases as far back as the Chu dynasty, that is about seven hundred years before Christ.

His own remedies are the following: Celestial pills which contain calomel; eliminating pills, which also contain calomel; silver nitrate pills, which contain mercury and nitrate of potash; five-element pills (having some relation to the sacred elements, wood, fire, metal, earth, water), which contain calomel; yellow illuminating powder, which contains calomel; precious-dew powder, which contains calomel; and another medicine which also contains calomel.

Poisoned diet—he means one a diet unfavorable to the patient—is advised as being unfavorable to the poison of syphilis. One poison drives out another; similis similibus. Calomel is not recommended at the beginning of syphilis.

Dr. H. Radcliffe-Crocker, of London, England, contributes a paper on "Lupus Erythematous as an Imitator of Various Forms of Dermatitis," describing numerous cases in which the disease simulated other affections of the skin. The paper is illustrated by a beautiful chromo-lithograph of one of the cases in which the disease simulated was lichen planus.

The remaining papers in this issue are: "A Case of Mycosis Fungoides" by Dr. R. A. McDonald McDonnell; and "Clinical Notes on Skin Diseases" by Dr. W. F. Breakey.

THE INTERNATIONAL JOURNAL OF SURGERY

for December. Dr. F. Byron Robinson contributes a paper on

The Pathology of the Fallopian Tube

in which he comes to the following conclusions:

1. The pathology of the Fallopian tube should be studied in regard to its structure, function and its connection with the peritoneum.

2. The inflammatory processes may be divided into three varieties, viz.: 1, endosalpingitis; 2, muscular salpingitis; 3, perisalpingitis (pelvic peritonitis).

3. The inflammatory process in the peritoneum spreads from the abdominal end of the tube in nearly all cases.

4. The nodular masses found in the pelvis are perisalpingitis and not cellulitis.

5. Autopsies demonstrate that severe perisalpingitis or pelvic peritonitis may exist, but the subperitoneal tissue will be as white as snow, as beautiful as hoar-frost.

6. Convoluted, contorted or spirally twisted tubes are accompanied by tubal colic. Such tubes are congenital or the result of subinvolution. The *tenia tubæ* enhances the condition.

7. At the bottom of most tubal trouble can be traced labor, abortion, gonorrhœa and sepsis.

8. A pyosalpinx can be changed into a hydrosalpinx and recover without operation.

9. Primary sarcoma, cancer, or tuberculosis of the tubes are quite rare.

10. No tube should be removed unless pathological conditions can be demonstrated in it, except for myoma and hysterical convulsions.

11. A prosalpinx should be removed on discovery.

12. Adhesions alone may be a sufficient cause for tubal removal on account of nerve pressure and irritation.

13. A large portion of the evil influences of tubal diseases is due to the irritation being transmitted to the abdominal brain, and then emitted to every viscus, destroying their rhythm and nutrition.

14. In removing tubes the ligature should be placed close up to the uterus, so that the menstruation will stop immediately by removing all the "automatic menstrual ganglia" belonging to the tube.

15. Uterine curetting in tubal disease should be judiciously employed. The author knows of several deaths from such procedure.

16. There is no doubt that much tubal pathology results from tinkering with the uterus, the introduction of sounds, unclean instruments, electrodes, and unnecessary curetting. Dilatation of the uterus is sometimes followed by tubal pathology.

Dr. Thomas H. Manley describes

A Bloodless Operation for Hemorrhoids.

The author advises local anaesthesia by means of cocaine applied hypodermically as by its means the patient is much more manageable than when under ether. The next step is thorough dilatation without which the operation will be a failure. To be painless and safe the dilatation must be gradual and steady or the muscle will be ruptured and the patient left incontinent. The third step in simple hemorrhoids is the separate treatment of each tumor by forcible pressure-massage. Before this is commenced, the entire cluster should be wiped clean and dry and then be freely mopped with the cocaine solution. Now, each hemorrhoid is separately seized, close to its base, firmly, between the tip of the thumb, index and middle fingers; first, put on a moderate, but full stretch; then twisted, and finally, so completely crushed that is reduced to a pulp, and none of the investing tunica remain, except the mucous membrane and its under stratum of fibrous tissue. When this has been completed, the entire mass is again pressed up, inside the sphincter; a suppository of opium

introduced, a pad and bandage applied, when the patient is returned to bed. An active, but painless inflammation follows; and, as a rule, within two or three weeks, resorption and atrophy have so reduced the vascular masses that nothing now remains but their shrunken, diminutive stenosis.

Dr. Samuel E. Milliken discusses

Diseases of the Joints in Children.

The author cautions against the acceptance of the well known phrase "growing pains" as applied to children. Pain is no more physiological in the child than in the adult and when it occurs should be investigated by the physician. He also advises the use of an anaesthetic in any tedious examination of a joint. Its use is advisable not alone to determine the lesion more readily but also because the subsequent treatment of the child can be carried out with less resistance if pain is not caused at the first examination. Conservatism should be the motto in the treatment of joint disease in children. It is the author's opinion that excision is only advisable in extreme cases as partial arthrectomy usually meets the requirements of such emergencies.

Dr. L. J. Lusk reports a case of

Penetrating Wound of Anterior Fossa through Orbital plate of Frontal Bone—Recovery.

The patient had been thrown by a runaway horse against a lamp-post, driving a piece of gas-pipe, with a blunt end five-eighth inches in diameter, into the forehead depth three of and one half inches. Her swaying body remained suspended in this position until removed by two strong men; one lifting the body, while the other pressed her head off the tube. The bones uniting to form the orbital floor were as completely removed as if it had been the work of the most skillful hand. There was also a fracture of the nasal eminence of the frontal bone. The eye-ball was uninjured except being completely separated from its attachments. Hemorrhage was quite profuse, but was controlled by cold compresses of sublimated water. An early hypodermic injection of $\frac{1}{2}$ gr. sulphate of morphine was given. The parts were thoroughly washed with hot sublimated water, 1-2000. At the point of deepest penetration, which was about three and one-half inches, the author used a 1-3000 solution in the cavity, the patient lying on her back; by turning slightly the face downward, the water ran out. After making the parts as thoroughly aseptic as possible, several strands of aseptic silk were introduced in the deepest perforation and the flaps united by interrupted sutures. The external dressing consisted of iodoform and boracic acid, and the whole covered with sublimated gauze and absorbent cotton.

Dr. A. B. Judson contributes a paper on "The Importance of Early Attention to the Disability Caused by Infantile Paralysis." In the department of the journal devoted to Railway Surgery, Dr. Emory Lanphear discusses "Meningeal Hemorrhages and their Treatment;" and Dr. George Chaffee contributes a paper on "Railway Surgery,"

Railway surgeons and their Societies." This issue also includes a report of the Annual Meeting of the New York Association of Railway Surgeons.

NEWS AND MISCELLANY.

Eleventh International Medical Congress.

A letter directed to the undersigned by the Secretary-General of the Eleventh International Medical Congress and dated December 19th, 1893, contains the following communications:

"American members will pay on the English, French, and Italian railways single fares for double journeys, and will obtain a reduction of twenty per cent. on fares for Italian round-trip tickets.

"The documents required for their identification will be sent to you in January, and Americans intending to visit the Congress will have to apply to you for them.

"Full particulars concerning the journeys will accompany the documents.

"Messers. Thos. Cook and Son, London, Paris, Rome, and Naples, should be applied to for accommodation and for tickets for the excursions at Rome, Naples, and to Sicily. Such excursions will be arranged at Rome under the guidance of Mr. Forbes, member of several scientific societies and correspondent of the "Times"—for Naples, three days, including Vesuvius, Pompey, Capri, Sorrento, Castellamare, Bajae, etc.—for Sicily, ten days from Naples, including Messina, Taormina, Catania, Girgenti, Siracusa, Palermo, and return to Naples.

"The fares for members of the Congress will be considerably reduced and comprise hotel accommodations, carriages, guides, boats, etc.—about 70 frs. each, for the three days, and 285 frs. for the ten days.

"Full particulars concerning these excursions will be contained in a leaflet to be added to the instructions and documents for the journey."

From former communications the following are herewith quoted. The members' fee is five dollars, that of their wives or adult relations two dollars each. Checks or money orders may be sent to Prof. L. Pagliani, Rome, Italy. Credentials have been promised in the near future. When they arrive (none

were received last year), they may be too late for many who have started or are about to start. The undersigned, who is not informed of the cause of delay, proposes to supply in as official a form as he thinks he is justified in doing, credentials which are expected to be of some practical value. The North German Lloyd has promised to recognize them. It is suggested, besides, that a passport may increase the traveler's facilities.

Only the North German Lloyd (22 Bowring Green) and the Compagnie Generale Transatlantique (3 Bowring Green) have thought fit to grant any reductions to Congressists.

The reduction on Italian railways are available from March 1st to April 30th.

A. JACOBI, M. D.,
110 W. 34th Street, New York.
January 11th, 1894.

Excursions to the National Capitol.

The Royal Blue Line has arranged a series of personally conducted three day tours from New York, Newark, Elizabeth, Trenton and Philadelphia to Washington, under the supervision of Thos. Cook & Son, the famous Tourist Agents. The dates selected are January 25, February 15, March 8, 29, April 19, 28, and May 10 and 17. The rate from New York, Newark and Elizabeth will be \$18.00, from Trenton \$12.25, and from Philadelphia \$11.00, which will include transfers between depot and hotel and first-class hotel accommodations at Washington. The train will leave New York on above dates from station, foot of Liberty Street, 9.00 A. M., leave Newark, C. R. R. of N. J., 8.55 A. M., Elizabeth, Royal Blue Line, 9.31 A. M., Trenton, P. & R., 10.20 A. M., Philadelphia, 12th & Market Streets, 11.26 A. M., and 24th & Chestnut Streets, 11.42 A. M., and will arrive at Washington 3.00 P. M.

The tickets will be valid for the return journey on any Royal Blue Line train within three days, including first day of sale, thus affording tourists an opportunity to visit the public buildings and places of interest in and about the Capitol.

For more detailed information call on or write Thomas Cook & Son, 261, 1225 Broadway, New York, or 828 Chestnut Street, Philadelphia.

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Theory and practice both demonstrate that Angier's Petroleum Emulsion, with Hypophosphites, is especially indicated in the treatment of La Grippe.

The antispasmodic and expectorant properties of the Petroleum control the spasmodic cough, relieve the irritable condition of the throat and larynx, and render expectoration free and easy. Its diaphoretic properties modify the fever and relieve the severe pains accompanying the same.

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These properties, together with its deleterious effects on the micro-organisms, make this Emulsion specially valuable in convalescence, as it restores the strength, relieves the cough, regulates the bowels, tones up the nervous system, and prevents bronchitis, pneumonia and other dangerous complications or lingering sequelae.

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the California Fig Syrup Company manufactured, from the juice of True Alexandria Senna and an excellent combination of aromatic aromatics with pure white sugar, the laxative which is now so well and favorably known under the trade name of "Syrup of Figs." With the exceptional facilities, resulting from long experience and entire devotion to the one purpose of making our product unequalled, this demand for the perfect laxative

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of extracting the laxative properties of Senna without retaining the griping principle found in all other preparations or combinations of this drug. This method is known only to us, and all efforts to produce cheap imitations or substitutes may result in injury to a physician's reputation, and will give dissatisfaction to the patient; hence, we trust that when physicians recommend or prescribe "Syrup of Figs" (Syr. Fici Cal.) they will not permit any substitution. The name "Syrup of Figs" was given to this laxative, not because in the process

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a few figs are used, but to distinguish it from all other laxatives, and the United States Courts have decided that we have the exclusive right to apply this name to a laxative medicine. The dose of

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as a laxative is one or two teaspoonfuls given preferably before breakfast or at bed time. From one-half to one tablespoonful acts as a purgative, and may be repeated in six hours if necessary.

"Syrup of Figs" is never sold in bulk. It is put up in two sizes to retail at fifty cents and \$1.00 per bottle, and the name "Syrup of Figs" as well as the name of the California Fig Syrup Company is printed on the wrappers and labels of every bottle.

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